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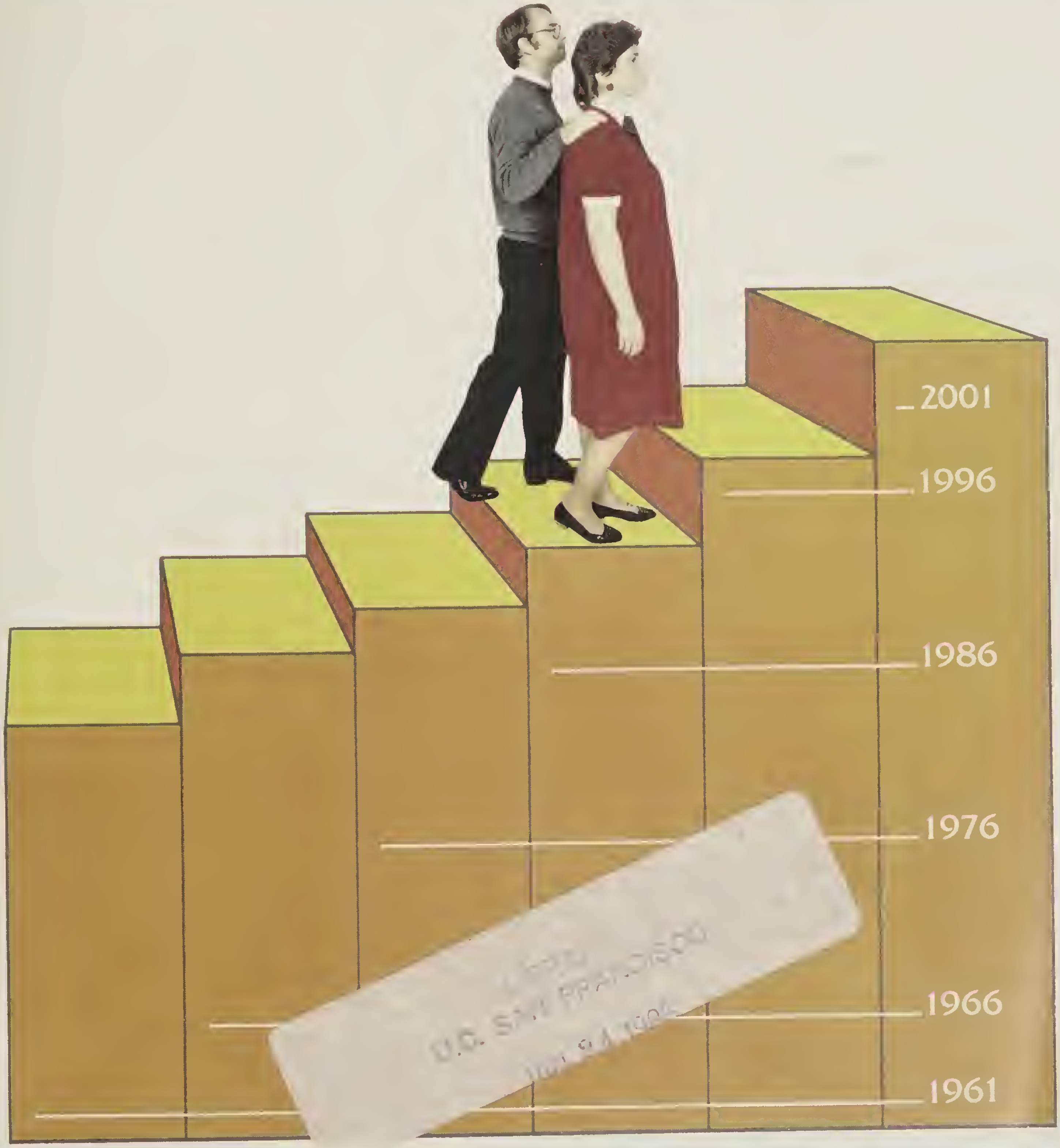
MICHIGAN MEDICINE

January, 1986 AWARD-WINNING JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 85, No. 1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Michigan Conference on Maternal and Perinatal Health
"25 Years of Growth and Change"

Michigan Conference
on Maternal and
Perinatal Health

March 19-20, 1986
Hyatt Regency Dearborn

"Twenty-five years of
Growth and Change"

For details: Sherry Fent, Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48823
(517) 337-1351

January 1986, Vol. 85, No. 1

MICHIGAN MEDICINE

About the cover: "Twenty-five Years of Growth and Change" is the theme of this year's Michigan Conference on Maternal and Perinatal Health. Our cover photo represents the growth of the body of knowledge in this important area of medicine.
Photo by Kim Kauffman.

Special report

5 The Michigan Conference on Maternal and Perinatal Health celebrates its Silver Anniversary this year—"Twenty-five Years of Growth and Change." Lee B. Stevenson, MD, remembers highlights of past meetings, and traces the progression of the conference's growth. A complete preliminary program details the topics to be covered at this year's event, March 19-20 at the Hyatt Regency Dearborn; Judy Marr.

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In next month's issue of *Michigan Medicine:* Computers in the medical office — what they can do for your practice.

Order your souvenir set of rally photos!

MSMS has selected six color photos representing the excitement of the entire "Onward to Lansing" rally day. Use the form at right to order.

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By Richard L. Rapport, MD

Preadmission certification and second surgical opinions

In the menagerie of medicine today Medicare, as well as many private health insurance contracts, requires some form of preadmission certification as a requisite for reimbursement. The insureds may not be aware of such requirements nor can physicians reasonably be expected to recognize specific coverage for each plan. At the same time second surgical opinion programs have been designed to review recommendations for surgery. Both of these programs have the clear intent of reducing the amount of hospital care and both have been promoted as cost containment or cost reduction approaches.

Sufficient evidence as to the cost saving potential or long range impact on the quality of care of second surgical opinion programs has not yet been identified. The Council of Medical Service of the AMA has developed policy calling for ongoing evaluation of second opinion programs stating:

"Third party payors, working with providers, should undertake conscientious evaluation of the methodologies and the result of current experimentation with coverage of second opinions prior to elective surgery. The long term results and general adaptability of such programs should be evaluated in terms of medical care quality, cost effectiveness, the cost and quality of alternative care provided in place of surgery, and the long range medical implications for the patient who did not have surgery."

Those who oppose preadmission review fear (with some justification) that this mechanism, as presently constituted by some third party payment programs, is intended only as a cost saving device. I am aware of no mechanism to identify patients in need of *more* intensive care than the attending physician recommends. There is certainly a possibility that preadmission

Continued on next page

Doctor Rapport, Flint, is a member of the MSMS Committee on Publications.

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Home health care resolution

MSMS recently received this etter from the AMA:

TO: Executive Directors
State Medical Associations
County Medical Societies
National Medical Specialty Societies
SUBJECT: Home Health Service Abuse

As you are aware, the AMA House of Delegates adopted Resolution 35 at its 1985 Annual meeting. The Resolution eads as follows:

Resolved, That the American Medical Association call upon the nation's physicians to write or carefully review all initial and renewal orders for home health services and approve only those that are medically indicated; and be it further

Resolved, That the AMA urge physicians to report to appropriate payment agencies and regulatory authorities cases of abusive practices by home health agencies; and be it further

Resolved, That the AMA urge physicians not to authorize the provision of home health services to any patient with whom he or she is not professionally involved in providing care.

Adoption of the Resolution was motivated by concern for assuring that the services provided to any patient by a home health agency are only those adjudged appropriate to the patient's needs by a physician involved in that patient's care. We encourage you to communicate this Resolution widely to your membership through all appropriate channels.

James Sammons, MD
Executive Vice President, AMA

PREADMISSION/Continued

eview may cause the patient o be uncertain of the need for reatment even when the reviewing body concurs with that need, causing inappropriate delays. It seems as though the physician's professional judgement is being second guessed by some formula-oriented approach managed by non-physicians. Compliance by physicians with preadmission eview requirements may entail significantly increased administrative costs. Opponents see it as a further restraint on he physician's professional autonomy, and as a new interposition between the patient and the physician.

The American Medical Association "opposes mandating blanket hospital preadmission review for all patients, or for specific categories of patients, by government, other peers or hospitals, while encouraging physician-directed peer review organizations to consider implementation of focused preadmission review on a voluntary basis."

Insurer's responsibility

It is certainly the insurer's responsibility to inform the patient and physician of preauthorization requirements. The Council on Medical Service of the AMA recommends that a mechanism be developed, such as a statement on the identification card issued by health insurers to the insured which will inform attending physicians that certification or preauthorization is required as a condition for payment.

The Council intends to meet with payors, employers, third parties and other concerned groups to explore the possibility of greater uniformity of administration and payor notification in both preadmission certification and second surgical opinion programs. It also will explore the feasibility of developing information and materials for physicians' offices to alert the patient to be aware of and to inform the physician of any preauthorization requirements applying to their insurance coverage. Although this strategy appears to be admirable I am concerned that such meetings will take a stamp of physician approval on both preadmission certification and second surgical opinion programs. Since it is inevitable that some patients will be harmed by these unproven cost saving mechanisms it might be better for physicians to strongly resist their implementation rather than make efforts to achieve uniformity of program design.

Will we, purportedly the managers of patient health care, relinquish our responsibility to health planners, legislators, hospitals and third parties?☐

By Judy Marr, Edito

MSMS Board of Directors supports Blues' mutualization

On December 4, the MSMS Board of Directors voted to support mutualization of Blue Cross Blue Shield of Michigan. The vote was 17 to 6, with two abstentions, and followed lengthy debate.

What was the thinking behind the Board's support of the Blues'' campaign?

Members of the Board's Health Care Delivery Committee, which recommended the action, reported they believe "under current legislation (Public Act 350 of 1981, which restructures the giant insurance company) BCBSM is certain to experience financial disaster. This would adversely impact patients, physicians and hospitals in Michigan."

The committee qualified its support by making it "contingent upon the assurance of adequate, reasonably priced health insurance for senior citizens, individual subscribers and other high risk groups."

James J. Humes, MD, Detroit pathologist, is chairman of the Health Care Delivery Committee. He also is a member of the Blue Cross Blue Shield of Michigan Board of Directors and chairman of its Professional Relations Committee.

"I have watched what has happened to the Blues with their underwriting problems," says Doctor Humes. "I believe they are doomed to fail unless they get out from under the onus of PA 350.

"I think we need the Blues in Michigan," he continues. "I think their only path to survival is to have the opportunity to form a mutual."

Doctor Humes has spoken with experts in Florida and Illinois where the Blues already have mutual companies. He asserts he has been assured that neither patients nor physicians have been disadvantaged by the mutual form of insurance company there.

"I was less than wildly enthusiastic about mutualization until BCBSM came out with its seniors program," he admits. "Our biggest problem is with our older people. We need reasonable, affordable health care for them and other small groups."

Richard L. Rapport, MD, Flint thoracic surgeon and member, MSMS Health Care Delivery Committee, makes these observations:

"Theoretically, there is no reason why mutualizaton should adversely influence payment to physicians. In their present status as a semi-regulated industry there is constant pressure by the Insurance Commissioner to keep rates down. To the extent that mutualization may protect BCBSM from almost certain bankruptcy, it should lessen the squeeze on payments to the physicians."

"In the final analysis our support for any change in BCBSM should be based on what we think will be best for our patients. We must make it clear to BCBSM that our support for mutualization will be contingent on their good faith assurances that our patients will continue to be covered at affordable rates."

Richard P. Horsch, MD, Farmington Hills, is president-elect, Wayne County Medical Society. He sums up the Board's rationale this way:

"Less regulated providers such as HMOs currently are "cherry-picking" large profitable patient groups without incurring the cost of subsidizing high risk subscribers. This allows them to offer, a greater benefit package than the Blues can offer, at the same cost as traditional Blues insurance. As a result, the Blues are rapidly losing their profitable low risk insurees while retaining their subsidized high risk insurees, creating what threatens to be an ever-increasing spiral of competitive inequity. The end result will be a marketplace dominated by HMOs and an insolvent Blues struggling to insure senior, single and urban subscribers. In this scenario, the rates charged to these remaining high-risk patient groups would price them right out of the insurance market place.

"It is the spectre of social catastrophe that I believe motivated the Board to appropriately endorse mutualization. It does not, in my opinion, constitute any form of endorsement of the Blues."

MSMS has a complete report on the mutualization of the Blues which is available from the Department of Medical Economics and Health Care Delivery.☐

By Judith Marr, Editor

Twenty-five years of Maternal Health Conferences

It hardly seems possible, but the 25th annual statewide conference on maternal and perinatal health is coming soon.

The 25th annual meeting, now called the Michigan Conference on Maternal and Perinatal Health, is scheduled March 19-20 at the Hyatt Regency Dearborn. Its participants will celebrate the meeting's quarter century of presentations.

One of the participants in the first meeting, Lee B. Stevenson, MD, Detroit, is ooking forward to attending the 25th. He is past chairman of the MSMS Committee on Maternal and Perinatal Health.

He recalls the 1962 event as "more of a retreat."

At that conference, the committee discussed its usual concerns in a resort setting on Gull Lake, near Kalamazoo. The two-day meeting was called the Michigan Conference on Maternal and Perinatal Welfare, and it was held in partnership with the Michigan Department of Health. It drew over 70 participants.

"There were 17 papers given, each dealing with some aspect of the aims of the conference," according to the 1962 report of the MSMS Committee on Maternal Health. "They were all excellent and the meeting was generally considered to have been most

Continued on next page

TWENTY FIVE YEARS/Continued

valuable. Interest was expressed in making this an annual event."

The 1963 event was held at Hickory Corners on Gull Lake again. "A stellar program is being arranged with attendance limited to 100," said the promotional article in the April, 1963 issue of the MSMS journal.

"The true highlights of the early conferences were the fellowship we enjoyed," says Doctor Stevenson. "We would stay up half the first night addressing personal as well as clinical things."

Key figures

The late William W. Jack, MD, Grand Rapids was instrumental in establishing both the concept and location of the meetings, recalls Doctor Stevenson. "He had an abiding interest in perinatology as well as in obstetrics. He developed a system for classifying perinatal mortality according to the triggering event rather than to the final diagnosis."

The 1981 conference was dedicated to Doctor Jack for his contributions.

Other key figures in the beginnings of the conference included the late James Harryman, MD, Muskegon, and the late Charles M. Bell, MD, Grand Rapids.

They obtained some funding the fourth year, which allowed them to put on a statewide conference for all interested physicians and other health professionals. They continued their Gull Lake retreats for the committee, while the conference moved to Flint.

"The standing joke was that as long as the conference was in Flint, we were sure to have a snowstorm,"' recalls Doctor Stevenson. "The same thing happened when we held the conference in Grand Rapids."

The co-sponsor of the Flint meetings was the Clara Elizabeth Fund, while the Michigan Society of Obstetricians and Gynecologists also helped support some of the conferences.

Several other organizations have contributed grants to the programs, including the Perinatal Association of Michigan; Michigan Section, Nurses Association, American College of Obstetricians and Gynecologists; the Michigan Chapter, American Academy of Pediatrics; Michigan Academy of Family Physicians; Michigan Nurses Association, and national pharmaceutical firms.

Doctor Jack served as conference chairman from 1962-67. Following him came Chairmen Jack W. Thompson, MD, Flint; Darrell Statzer, MD, Detroit; Joseph L. Sheets, MD, Lansing; Richard Mellis, MD, Kalamazoo; Lloyd A. Kameraad, MD, Grand Rapids; Kenneth J. VanderKolk, MD, Grand Rapids; John M. DeVries, MD, Kalamazoo; John V. Hartline, MD, Kalamazoo; Bruce A. Work, MD, Ann Arbor; John W. Hallitt, MD, Flint; Gerald B. Holzman, MD, Lansing; Rudi Ansbacher, MD, Ann Arbor, and Robert W. Dustin, MD, Dearborn.

Several of these men have been Maternal Health Conference chairmen more than once. Current co-chairmen are Doctors Ansbacher and Dustin.

Among speakers have been national figures such as S. Leon Israel, MD, Philadelphia, editor, *Obstetrics and Gynecology*; John Ditzler, MD, now a national head of the Veterans Administration hospital system; Charles U. Lowe, MD, Bethesda, executive director, National Commission for Protection of Human Subjects, National Institutes of Health; Edith Potter, MD, noted Chicago pathologist; John Rock, MD, New York, world authority on birth control, and Mona Shanggold, MD, national nutritional expert from the Department of Obstetrics and Gynecology at the Georgetown University School of Medicine, Washington, DC.

The meeting has been a favorite of Doctor Stevenson's over the years.

"I don't get to go to every maternal health conference," he confides. "But I get to go to this one, and I'm looking forward to it."

"There's always something worthwhile, something of enough clinical importance that you can use it in discussions with patients and residents."□

Goals and Objectives for the Annual Michigan Conference on Maternal and Perinatal Health

"25 Years of Growth and Change"

The perinatal health care professional, through attendance at this conference will have an opportunity to interact with a multidisciplinary faculty addressing "FACTORS INFLUENCING FETAL OUTCOME." At the conclusion of the conference, the participant should be able to:

PRE-CONCEPTIONAL FACTORS

- recognize the changing concepts in maternal and infant care Michigan has experienced over the past 25 years.
- understand the medical, ethical, and social significance of pregnancy planning for the higher risk population.
- select those patients for whom genetic counseling should be pursued, as well as understand the newer techniques available for detecting in utero problems.
- discuss the effects of maternal age, nutrition, stress, and working environments on pregnancy.
- describe those factors which need to be addressed when screening for increased risk of premature delivery.
- explain the benefits of normal exercise and discuss the potential hazards of vigorous exercise during pregnancy.

INTRAUTERINE AND NEONATAL FACTORS

- differentiate premature labor from other causes of uterine contractions and discuss the significance of its early recognition.
- incorporate into antenatal surveillance the importance of fetal movements.
- discuss the maternal and fetal problems relating to hypertension in pregnancy and explain the rationale for treatment.
- express an awareness of the need for accurate pregnancy dating and identify the problems associated with a post mature infant.
- list specific bacterial and viral infections affecting pregnancy and relate these to potential consequences in the neonatal period.
- explain the problems of intrauterine growth retardation; specifically, the diagnosis and management options in utero, the neonatal complications, and long term prognosis.
- understand the prevailing factors resulting in intrauterine asphyxia.
- cite methods and non-invasive approaches to various neonatal diagnoses.
- identify changes in the health care system that have significant implications regarding patient care and patient participation during pregnancy and the neonatal period; specifically, home glucose monitoring and home management of neonatal lung diseases.

It is believed that interaction between participants at this conference will offer broadened perspectives and enlightenment toward the future for those involved in perinatal health care.

The Maternal and Perinatal Health Conference Planning Committee

Robert W. Dustin, MD, Co-chairman, Dearborn
Joseph P. Metz, MD, Co-chairman, Flint
John R. Addy, MD, Lansing
Silvio Aladjem, MD, Kalamazoo
Rudi Ansbacher, MD, Ann Arbor
C. Arch Brown, MD, Flint
Mary M. Conklin, RN, Lansing
Miriam S. Daly, MD, Albion
Steven M. Donn, MD, Ann Arbor
Molly Gates, RN, Ann Arbor
John V. Hartline, MD, Kalamazoo
Joy Hirschberger, RN, Grand Blanc
Okjin Kim, RN, Lansing
Mary J. Kokosky, MD, Dearborn
Chang Y. Lee, MD, Detroit
Robert P. Lorenz, MD, Royal Oak
Federico G. Mariona, MD, Detroit
John G. O'Rourke, MD, Jackson
Evelyn Piehl, RN, Ann Arbor
Mary A. Scoblic, RN, Lansing
Mindy Smith, MD, Chelsea
Lloyd A. Kammeraad, MD, ex-officio, Grand Rapids
Hermann A. Ziel, Jr., MD, ex-officio, Lansing

Wednesday morning, March 19

"Factors Influencing Fetal Outcome"

7:30
Registration

8:15 to 8:30
Welcome/Moderator: Richard J. McMurray, MD, President, Michigan State Medical Society, Flint

8:30 to 9:00
Keynote, "Maternal and Infant Care in Michigan: The Past 25 Years"
Harvey Day, PhD, Executive Vice President, Chief Operating Officer, Michigan Health Care Corporation, Detroit

A brief tour of our recent past reflects many key accomplishments in improving maternal and infant care. These achievements represent technological and scientific breakthroughs - our successes. What of our missed opportunities?

9:00 to 9:20
"Planning for Pregnancy"
Kenneth J. VanderKolk, MD, Director, Obstetrics and Gynecology Education, Butterworth Hospital, Grand Rapids; Professor, Department of Obstetrics and Gynecology, Michigan State University College of Human Medicine

Should the obstetric care of women contemplating pregnancy begin before conception? Many experts agree such care should be expanded to include preconceptional screening exam, dietary and exercise advice and recognition of risk factors.

9:20 to 9:40
"Practical Genetic Counseling"
Lester Weiss, MD, Director of Medical Genetics and Birth Defects Center, Henry Ford Hospital, Detroit; Clinical Professor of Pediatrics, University of Michigan Medical School

A brief review of the principles and techniques of molecular genetics will be presented with examples of current practical applications in genetic counseling and prenatal diagnosis. Sickle cell anemia, thalassemia, Huntington's disease, and Duchenne's muscular dystrophy will be discussed.

9:40 to 10:00
"Implications of Maternal Age"
Ann E. Swinford, MS, Genetics Counselor, Department of Pediatrics & Human Development, Michigan State University College of Human Medicine

The risk for fetal chromosomal abnormalities increases with maternal age. Amniocentesis, chorionic villus sampling, and maternal serum alpha feto-protein testing will be discussed, along with the increased risk of pregnancy loss with maternal age.

10:00 to 10:30
Break

10:30 to 11:00
"Nutrition"
Mona Shangold, MD, FACOG, Assistant Professor, Department of Obstetrics and Gynecology; Director, Sports Gynecology Center, Georgetown University School of Medicine, Washington, D.C.

Twenty-five per cent of reproductive-age women are iron-deficient, and five per cent are anemic. Iron-deficiency can impair work and athletic performance. Most women consume insufficient dietary calcium and would benefit from a combination of adequate calcium, normal estrogen levels and weight-bearing exercise.

11:00 to 11:30
"Stress and the Work Environment"
Mindy Smith, MD, Family Practitioner, Chelsea

11:30 to 12:00
Question and Answer Session:
All Speakers

12 NOON
Adjourn to Luncheon Meetings:

"Bacterial Infection in Newborns"
Alistair G. S. Philip, MD, Professor of Pediatrics, University of Vermont College of Medicine; Director, Division of Neonatology, Maine Medical Center, Portland

Because the newborn infant is highly susceptible to bacterial infection, it is important to distinguish the infected infant from those with similar clinical findings who are not infected. Leukocyte counts and acute phase reactants can provide valuable diagnostic information to institute or discontinue therapy.

"Exercise in Pregnancy"
Mona Shangold, MD, FACOG, Assistant Professor, Department of Obstetrics and Gynecology; Director, Sports Gynecology Center, Georgetown University School of Medicine, Washington, D.C.

Women accustomed to aerobic exercise before pregnancy can expect to continue it during an uncomplicated pregnancy. Women not accustomed to aerobic exercise before pregnancy should not practice any aerobic sport more vigorous than walking. Weight-training is advisable for all pregnant women regardless of prior exercise habits.

"Screening for Risk of Prematurity - Strengths and Weaknesses"
Michael Katz, MD, Assistant Professor, Department of Obstetrics and Gynecology, Children's Hospital and the University of California, San Francisco
While the specificity and negative predictive value of present scoring systems which screen for the risk of prematurity are relatively good, their sensitivity and positive predictive value are relatively poor. There is a definite need for new biochemical and biophysicial markers.

"Certified Nurse-midwifery: We Are Making Progress"
Thersa B. O'Rourke, CNM, MPH, Nurse-midwife, Department of Maternal & Fetal Medicine, Sinai Hospital of Detroit

An update on the range of certified nurse-midwifery services, as well as innovative and new programs in Michigan, will be presented.

"Fetal Activity: Normal and Abnormal"
Silvio Aladjem, MD, Director, Perinatal Services, Bronson Methodist Hospital, Kalamazoo; Clinical Professor, Obstetrics and Gynecology, Wayne State University

Fetal movement is an efficient expression of fetal well-being. Clinical application of fetal activity will be reviewed and limitations of the technique and its future applications will be explored.

Wednesday afternoon, March 19

Moderator: Kenneth J. VanderKolk, MD, Director, Obstetrics and Gynecology Education, Butterworth Hospital, Grand Rapids; Professor, Department of Obstetrics and Gynecology, Michigan State University College of Human Medicine

1:30 to 2:00
"Early Diagnosis of Preterm Labor"
Michael Katz, MD, Assistant Professor Department of Obstetrics and Gynecology, Children's Hospital and the University of California, San Francisco

A major obstacle in reducing current preterm birth rates through tocolysis is the inability to make an early diagnosis of preterm labor. Daily ambulatory home tocodynamometry for patients at high risk may enhance an early diagnosis and improve pregnancy outcome.

2:00 to 2:45
"Perinatal Hypoxia: The Pathologic Correlates"
Federico Mariona, MD, Director, Maternal-Fetal Medicine, Department of Obstetrics and Gynecology, Wayne State University/Hutzel Hospital, Detroit

The obstetrician's ability to identify women at risk for potentially abnormal obstetrical outcome has increased in the last few years. This involves the use of invasive and non-invasive techniques to assess the intrauterine environment.

2:45 to 3:00
Question and Answer Session
Doctors Katz and Mariona

3:00 to 3:30
Break

3:30 to 4:30
"Non-invasive Neonatal Diagnosis"
Alistair G. S. Philip, MD, Professor of Pediatrics, University of Vermont College of Medicine; Director, Division of Neonatology, Maine Medical Center, Portland

Non-invasive techniques have emerged to avoid "intrusive" neonatal intensive care. Such techniques include: transillumination, transcutaneous blood gas analysis and bilirubinometry, intracranial pressure monitoring, ultrasound, and magnetic resonance imaging and spectroscopy.

4:30 to 4:45
Question and Answer Session
Doctor Philip

4:45
Adjournment

The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation certifies that this activity, the Michigan Conference on Maternal and Perinatal Health, meets the criteria for a maximum of 13 hours in Category I toward the requirements for Michigan licensure and of the Physician Recognition Award of the AMA, provided it is completed as designed.

Thursday morning, March 20

7:30
Registration

Moderator: Bruce H. Drukker, MD, Chairman, Department of Obstetrics and Gynecology, Michigan State University College of Human Medicine

8:15 to 8:45
"Hypertension"
Preston V. Dilts, Jr., MD, Bates Professor and Chairman, Department of Obstetrics and Gynecology, University of Michigan Medical School

This lecture will enable the participant to recognize the problems in diagnosing and treating mild and severe hypertension in pregnancy; propose treatment programs for both mild and severe hypertension; and recognize and be prepared to treat complications of mild and severe hypertension.

8:45 to 9:15
"IUGR: Fetal Problems"
Lawrence E. Stempel, MD, Clinical Assistant Professor, Department of Obstetrics and Gynecology, Ohio State University College of Medicine, Columbus

Conceptual aspects of intrauterine growth retardation will be discussed, along with the diagnosis and management options.

9:15 to 9:45
"Problems of the IUGR Newborn"
Seetha Shankaran, MD, Associate Professor, Department of Pediatrics, Wayne State University School of Medicine; Associate Neonatologist, Children's Hospital of Michigan and Hutzel Hospital, Detroit

We will discuss identification of the growth-retarded neonate, pathophysiology evaluation and management of specific problems such as perinatal asphyxia, hypoglycemia, meconium aspiration syndrome and polycythemia-hyperviscosity syndrome. Neuro developmental follow-up of IUGR neonates will also be addressed.

9:45 to 10:00
Question and Answer Session:
Doctors Dilts, Shankaran and Stempel

10:00 to 10:20
Break

10:20 to 10:45
"Uncertain Dates"
Chang Y. Lee, MD, Head, Division of Maternal-Fetal Medicine, Henry Ford Hospital; Clinical Associate Professor, Department of Obstetrics and Gynecology, University of Michigan Medical School

Uncertain gestational age in the management of premature labor, suspected intrauterine growth failure, and suspected postdate pregnancy will be discussed.

10:45 to 11:10
"The Postmature Infant"
Steven M. Donn, MD, Associate Professor of Pediatrics, Section of Newborn Services, University of Michigan Medical Center, Ann Arbor

The postmature infant is at risk for multiple problems which jeopardize well-being. Among these are meconium aspiration syndrome, hypoglycemia, hyperviscosity, persistent pulmonary hypertension, and asphyxia. Awareness and anticipation are the keys to successful neonatal management.

11:10 to 11:45
"The Silent Partner"
Charles H. Sander, MD, Professor of Pathology, Director of the Michigan Placental Tissue Registry, Michigan State University College of Human Medicine

The placenta performs vital functions during intrauterine life. Despite this important role, it has been neglected by those caring for the pregnant patient. This presentation focuses on processes which can be recognized by placental examination and reflect important clinical information.

11:45 to 12:00
Question and Answer Session:
Doctors Donn, Lee and Sander

12 NOON
Adjourn to Luncheon Meetings:

"Preconceptional Counseling of Couples with Recurrent Pregnancy Loss"
Preston V. Dilts, Jr., MD, Bates Professor and Chairman, Department of Obstetrics and Gynecology, University of Michigan Medical School

A brief summary of the events surrounding high risk pregnancy and delivery will be presented. This will include discussion of possible counseling efforts which could improve the outcome.

"Congenital, Non-Bacterial Infections"
Roger G. Faix, MD, Assistant Professor, Department of Pediatrics, University of Michigan Medical School

Congenital infections remain a major cause of

Thursday afternoon, March 20

Thursday Luncheons/Continued

mortality and morbidity in the United States, affecting approximately 75,000 newborns every year. Clinical problems associated with the many possible causative agents will be reviewed. Strategies for prevention, diagnosis, and treatment will be discussed.

"Ultrasound"
Lawrence E. Stempel, MD, Clinical Assistant Professor, Department of Obstetrics and Gynecology, Ohio State University College of Medicine, Columbus

Practical aspects of 1st trimester scanning, including multiple gestation, ectopic pregnancy and bleeding will be reviewed.

"Joint Practice: Is It a Reality?"
Sharon Hudson, RN, CNM, Director, Division of Perinatal Nursing, Hutzel Hospital, Detroit

"Outcome of the NICU Grad"
David Sciamanna, DO, Neonatologist and Director, Developmental Assessment Clinic, E.W. Sparrow Hospital; Assistant Professor, Department of Pediatrics, Michigan State University Colleges of Osteopathic and Human Medicine

The improved survival of smaller newborns brings both good and disturbing news. Consideration must be given to those babies with stormy nursery courses so that any morbidity which may be realized later can be detected as early as possible.

"Patient Participation in Health Care"

Moderator: Joseph Metz, MD, Flint, Conference Co-chairman

1:30 to 2:15
"Collaboration: New Challenges for Caregivers"
Molly R. Gates, RNC, MSN, Perinatal Outreach Coordinator, University of Michigan Medical Center

Kathleen R. Larkin, RNC, MSN, Clinical Nurse Specialist, Pontiac General Hospital, Pontiac

High risk perinatal care has evolved into a highly specialized, but sometimes fragmented experience. Coordination and collaboration among consumers and providers is essestial.

2:15 to 2:45
"Home Health Care: Concession or Concession?"
Markey Butler, President, AMICARE Home Health Services, Sisters of Mercy Health Corporation, Ann Arbor

The changing relationship between health care systems and financial intermediaries continue to alter our practice. Increasingly, the delivery system involves home care. How can the health care provider respond to ensure quality and continuity?

2:45 to 3:00
Break

3:00 to 3:20
"Maternal Diabetes: How Sweet it Isn't"
Robert P. Lorenz, MD, Director, Maternal and Fetal Medicine, William Beaumont Hospital, Royal Oak

Metabolic control in the pregnant insulin-dependent diabetic is of paramount importance in improving perinatal outcome. Principles, methods, timing, equipment, and the role of a multidisciplinary team will be addressed.

3:20 to 3:40
"Home Management of Neonatal Lung Disease"
Mary E. A. Bozynski, MD, Assistant Professor of Pediatrics, Medical Coordinator of the Neonatology Developmental Assessment Clinic, University of Michigan Medical Center

Successful home management of infants with residual lung disease requires careful predischarge planning; detailed follow-up; and most importantly, close cooperation and communication between family, primary care physician, neonatal center staff, and community support and financial providers.

3:40 to 3:50
Question and Answer Session

3:50 to 4:30
"What's Ahead"
Kenneth VanderKolk, MD, Professor, Department of Obstetrics and Gynecology, Michigan State University College of Human Medicine; Program Director of Obstetrics and Gynecology Education, Butterworth Hospital, Grand Rapids

Survival in the marketplace of obstetrical care, who will control the health care field, preparation for technological explosions, and the support of graduate medical education are all questions of present and future concern. We will take a look at the somewhat cloudy crystal ball for answers to the above issues.

4:30
Conference Adjourns

Annual Michigan Conference on Maternal and Perinatal Health

"25 years of Growth and Change"

March 19-20, 1986 Hyatt Regency Dearborn

Wednesday, March 19
"Factors Influencing Fetal Outcome"

7:30 a.m.	Registration
8:15 a.m.	Welcome
8:30 a.m.	Keynote, "Maternal and Infant Care in Michigan: The Past 25 Years"
9:00 a.m.	"Planning for Pregnancy"
9:20 a.m.	"Practical Genetic Counseling"
9:40 a.m.	"Implications of Maternal Age"
10:00 a.m.	Break
10:30 a.m.	"Nutrition"
11:00 a.m.	"Stress and the Work Environment"
11:30 a.m.	Q & A Session
12 NOON	Adjourn to Luncheon Meetings

Wednesday afternoon

1:30 p.m.	"Early Diagnosis of Preterm Labor"
2:00 p.m.	"Perinatal Hypoxia: The Pathologic Correlates"
2:45 p.m.	Q & A Session
3:00 p.m.	Break
3:30 p.m.	"Non-invasive Neonatal Diagnosis"
4:30 p.m.	Q & A Session
4:45 p.m.	Adjournment

Thursday, March 20
"Factors Influencing Fetal Outcome"

7:30 a.m.	Registration
8:15 a.m.	"Hypertension"
8:45 a.m.	"IUGR: Fetal Problems"
9:15 a.m.	"Problems of the IUGR Newborn"
9:45 a.m.	Q & A Session
10:00 a.m.	Break
10:20 a.m.	"Uncertain Dates"
10:45 a.m.	"The Postmature Infant"
11:10 a.m.	"The Silent Partner"
11:45 a.m.	Q & A Session
12 NOON	Adjourn to Luncheon Meetings

Thursday afternoon
"Patient Participation in Health Care"

1:30 p.m.	"Collaboration: New Challenges for Caregivers"
2:15 p.m.	"Home Health Care: Concession or Concession?"
2:45 p.m.	Break
3:00 p.m.	"Maternal Diabetes: 'How Sweet it Isn't'"
3:20 p.m.	"Home Management of Neonatal Lung Disease"
3:40 p.m.	Q & A Session
3:50 p.m.	"What's Ahead"
4:30 p.m.	Conference Adjourns

- -

Advance Registration For Michigan Conference on Maternal and Perinatal Health

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(Please print) (first) (initial) (last)

Address______________________________________

City, State__________________ Zip__________ Phone______________

MSMS Member: Yes_______ No_______ Specialty__________________

Nurse_______ Resident_______ Other__________________________

Tuition Schedule

Physicians: $40 each General Session
Nurses: $25 each General Session
Others: $25 each General Session
Residents & Students: No Charge for General Session
Luncheon: $10 for All Registrants

Wednesday, March 19, 1986

☐ General Session $_____
☐ Luncheon Meetings (indicate 1st & 2nd choices): $_____
____ Bacterial Infection/Newborns
____ Exercise in Pregnancy
____ Screening for Prematurity
____ Certified Nurse-midwifery
____ Fetal Activity

Wednesday Total = $_____

Thursday, March 20, 1986

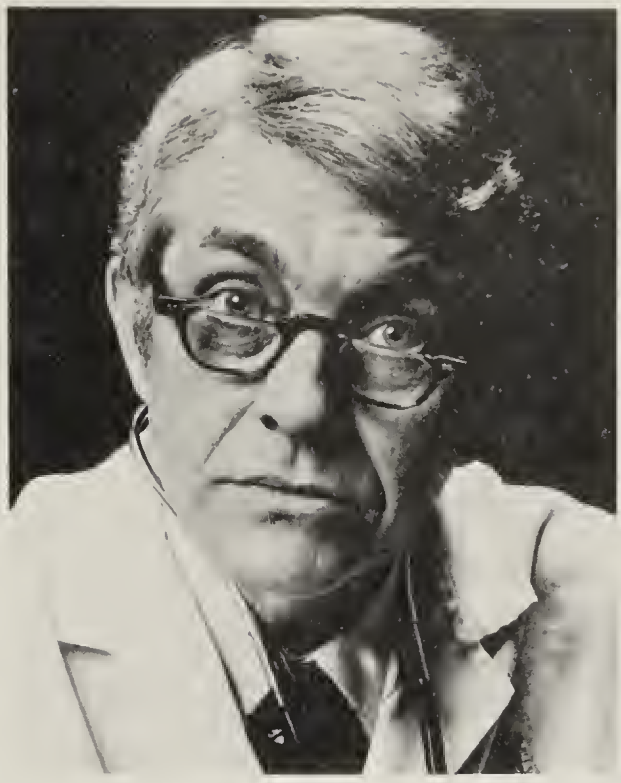
☐ General Session $_____
☐ Luncheon Meetings (indicate 1st & 2nd choices): $_____
____ Preconceptional Counseling
____ Congenital Infections
____ Ultrasound
____ Joint Practice: Reality?
____ The NICU Grad

Thursday Total = $_____

Checks payable to:
Michigan State Medical Society

GRAND TOTAL = $__________

Please complete and mail with your check to MSMS, P.O. Box 950, East Lansing, MI 48823, (517/337-1351). Confirmation of your registration will be sent to you with a hotel reservation card.



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Professional liability legislation update

This update on proposed professional liability legislation is reprinted from the December 3, 1985 issue of the *GRA Sheet* (MSMS Government Relations Agenda). Information on other health-related bills will be published next month.

This issue of the *GRA Sheet* provides you with the status of all professional liability bills currently being addressed by the legislature.

It is extremely important that you continue to write/call your state legislators in support of professional liability reforms in Michigan. When contacting your legislators, please place special emphasis on the need for a stricter statute of limitations; a cap on noneconomic damages; stricter qualifications for expert witnesses; pre-trial screening mechanisms; and modifying the collateral source rule. You will be kept updated and informed as the professional liability package moves through the legislative process.

If you have any questions concerning the *GRA Sheet*, please contact Kevin A. Kelly at MSMS headquarters.

Frederick V. Minkow, MD,
Chairman
MSMS Committee on State
Legislation and Regulations

Senate Package on Professional Liability

Senate Bill 463 — Sanctions on Out-of-State Physicians
Sponsor: Senator William Sederburg — (R-Lansing)
SB 463 would require sanctions on out-of-state physicians licenses to be applied to Michigan licenses. Introduced 10/2/85. Passed 11/5/85. Sent to House Appropriations Committee.

Senate Bill 466 — Joint and Several Liability
Sponsor: Senator Gilbert DeNello — (D-East Detroit)
SB 466 would allow for exceptions to joint and several liability under civil litigation. Introduced 10/2/85. Passed 10/17/85. Sent to House Appropriations Committee.

Senate Bill 467 — Insurance Evidence
Sponsor: Senator Harmon Cropsey — (R-Decatur)
SB 467 would allow the admission of insurance coverage as evidence in civil litigation. Introduced 10/2/85. Passed 10/17/85. Sent to House Appropriations Committee.

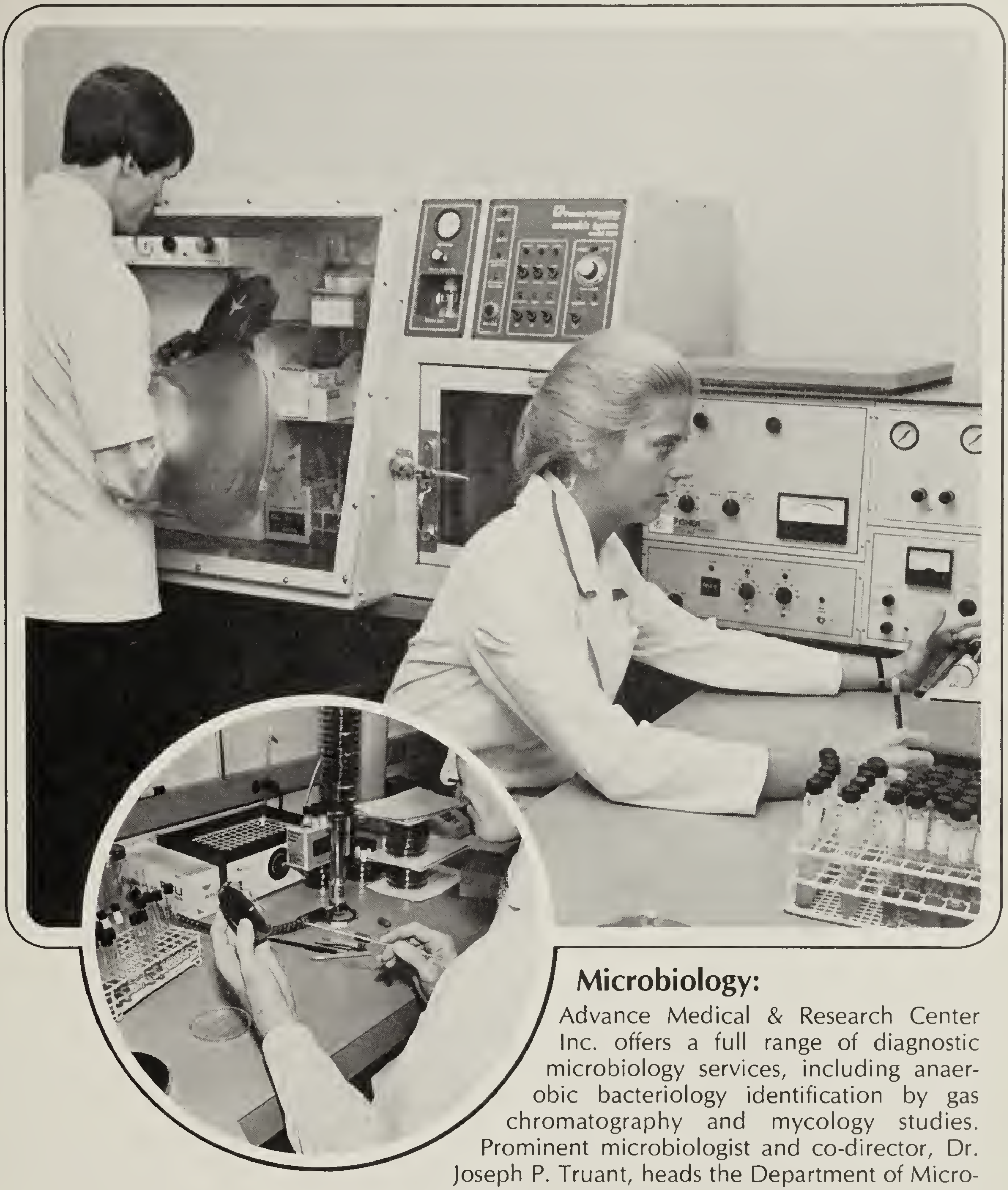
Senate Bill 468 — Civil Actions/Frivolous Suits
Sponsor: Senator Richard Posthumus — (R-Lowell)
SB 468 would require a court to award costs and fees to the prevailing party if the court finds the action was frivolous or intended solely for harassment. Introduced 10/2/85. Passed 10/17/85. Sent to House Appropriations Committee.

Senate Bill 469 — Interest on Judgments
Sponsor: Senator Norman Shinkle — (R-Lambertville)
SB 469 would require interests on judgment awards be based on the interest rate of five-year US Treasury bills. Introduced 10/2/85. Passed 10/17/85. Sent to House Appropriations Committee.

Senate Bill 470 — Medical Malpractice/Tort Reform
Sponsor: Senator Alan Cropsey — (R-DeWitt)
SB 470 would define an expert witness; redefine medical malpractice; limit noneconomic damages; provide for itemized and structured verdicts; permit eriodic payments; abolish the joint and several liability rule; mandate pre-trial review panels, and change the statute of limitations. Introduced 10/2/85. Passed 10/17/85. Sent to House Appropriations Committee.

Senate Bill 471 — Collateral Source Rule
Sponsor: Senator Patrick McCollough — (D-Dearborn)
SB 471 would allow the admission of collateral source as evidence for medical malprac-

Continued on page 16



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tice action. Introduced 10/2/85. Passed 10/17/85. Sent to House Appropriations Committee.

Senate Bill 472 — Patient Medical Records
Sponsor: Senator Dan DeGrow — (R-Port Huron)
SB 472 would prohibit a health professional licensee from falsifying or destroying a patient's records and from providing misleading information regarding a patient's treatment; establishes penalties. Introduced 10/2/85. Passed 10/17/85. Sent to House Appropriations Committee.

Senate Bill 473 — Patient Medical Records
Sponsor: Senator Dan DeGrow — (R-Port Huron)
SB 473 is similar to SB 472 but amends the penal code to prohibit and set penalties for falsifying or destroying information in medical patients records or charts or providing patients with misleading or inaccurate information. Introduced 10/2/85. Passed 10/17/85. Sent to House Appropriations Committee.

Senate Bill 474 — Late Payment Fees; Licensure
Sponsor: Senator Alan Cropsey — (R-DeWitt)
SB 474 would permit the Department of Licensing and Regulation to impose a reasonable late payment fee upon persons (all except health care professionals) who fail to renew their licenses or certificates of registration prior to expiration. The bill confers civil immunity upon board members while performing their board duties. Introduced 10/2/85. Passed 10/17/85. Sent to House Appropriations Committee.

Senate Bill 475 — Health Care Professionals
Sponsor: Senator John Kelly — (D-Detroit)
SB 475 would strengthen the licensing requirement of, sanction against, and regulatory oversight of health care professionals. It would also limit the liability of members of health licensing boards. Introduced 10/2/85. Passed 10/17/85. Sent to House Appropriations Committee.

Senate Bill 476 — Physician Investigation
Sponsor: Senator Rudy Nichols — (R-Pontiac)
SB 476 would require the automatic investigation of a physician who has had three or more malpractice settlements, judgments, or awards totaling not less than $200,000 within a ten year period. Introduced 10/2/85. Passed 10/17/85. Sent to House Appropriations Committee.

Senate Bill 477 — Health Licensing Board Sanctions
Sponsor: Senator Alan Cropsey — (R-DeWitt)
SB 477 would require that sanctions against a physician imposed by the Michigan Board of Medicine and Surgery remain in effect during an appeal. Introduced 10/2/85. Passed 10/17/85. Sent to House Appropriations Committee.

Senate Bill 484 — Board of Medicine/Medical Administrator
Sponsor: Senator Robert Geake — (R-Northville)
SB 484 would require the Department of Licensing and Regulations to appoint a medical administrator and hire additional investigative staff for the Board of Medicine. Introduced 10/2/85. Passed 10/17/85. Sent to House Insurance Committee.

Senate Bill 493 — Malpractice Arbitration
Sponsor: Senator Nick Smith — (R-Addison)
This bill would provide for the stopping of the 60-day revocation period under the Medical Malpractice Act if the person dies during the 60-day period or if the appointed representative is unaware of an arbitration agreement and until the representative became aware of such agreement. Introduced 10/3/85. Passed 11/19/85. Sent to House Insurance Committee.

Senate Bills 494 and 495 — Malpractice Arbitration
Sponsor: Senator Nick Smith — (R-Addison)
These bills would provide for the notice of a medical malpractice arbitration provision to be provided to subscribers of health maintenance organization contracts and under prudent purchaser agreements and coverage authorized by the Prudent Purchaser Act. Introduced 10/3/85. Passed 11/19/85. Sent to House Insurance Committee.

Senate Bill 577 — Catastrophe Insurance
Sponsor: Senator Jack Faxon — (D-Southfield)
This bill would establish a limit of $200,000 for payment by insurance companies for malpractice coverage and provides catostrophe insurance to cover any excess award. Introduced 11/12/85. Referred to Senate Commerce Committee.

Senate Bill 578 — Physician Liability Association
Sponsor: Senator Jack Faxon — (D-Southfield)
This bill would require doctors to participate in a physician's liability association as a condition for licensing. Introduced 11/12/85. Referred to Senate Commerce Committee.

House Package on Professional Liability

House Bill 4673 — Immunity for Health Licensing Board Members
Sponsor: Representative James O'Neill — (D-Saginaw)
This bill would grant immunity from civil lawsuits to health licensing board members. Introduced 5/8/85. Passed

11/6/85. Sent to Senate Commerce Committee.

House Bill 4675 — Health Care Sanctions
Sponsor: Representative Wilbur Brotherton — (R-Farmington)
This bill provides that sanctions imposed by the Board of Medicine or Board of Osteopathic Medicine and Surgery remain in effect while pending appeal. Introduced 5/8/85. Referred to House Judiciary Committee.

House Bill 4680 — Hospital Notification of Disciplinary Actions
Sponsor: Representative Robert Emerson — (D-Flint)
This bill would require hospitals to notify the appropriate licensing board of any disciplinary action which results in change of employment or staff privileges. Introduced 5/8/85. Passed 6/11/85. Sent to Senate Public and Mental Health Committee.

House Bill 4786 — Arbitration
Sponsor: Perry Bullard — (D-Ann Arbor)
This bill would provide for the enforcement of arbitration awards and would allow for actual attorney fees and costs. Introduced 5/28/85. Referred to the House Judiciary Committee.

House Bill 5039 — Shorter Statute of Limitations
Sponsor: Representative Terry London — (R-Smiths Creek)
This bill would provide for a shorter statute of limitations in medical malpractice actions. Introduced 10/1/85. Referred to House Judiciary Committee.

House Bill 5040 — Pre-trial Screening Panels
Sponsor: Representative Terry London — (R-Smiths Creek)
This bill would require pre-trial screening panels for medical malpractice actions. Introduced 10/1/85. Referred to House Judiciary Committee.

House Bill 5062 — Recovery of Costs to Defendant
Sponsor: Representative Victor Krause — (R-Rockford)
This bill would provide for the full recovery of costs and fees by a successful defendant in certain civil actions. Introduced 10/7/85. Referred to House Judiciary Committee.

House Bill 5090 — Comparative Negligence
Sponsor: Representative John Strand — (R-Lapeer)
This bill would provide for the use of comparative negligence in determining liability in civil actions. Introduced 10/17/85. Referred to House Judiciary Committee.

House Bill 5091 — Cap on Non-economic Damages
Sponsor: Representative Alvin Hoekman — (R-Holland)
This bill would limit the amount of damages recoverable for noneconomic loss to $250,000 per person. Introduced 10/17/85. Referred to House Judiciary Committee.

House Bill 5092 — Periodic Payments of Judgments
Sponsor: Representative Richard Bandstra — (R-Grand Rapids)
This bill would require judgments for future damages to be paid in periodic payments. Introduced 10/17/85. Referred to the House Judiciary Committee.

House Bill 5094 — Collateral Source Payments
Sponsor: Representative David Honigman — (R-W. Bloomfield)
This bill would reduce damage judgments based on any collateral source payments. Introduced 10/17/85. Referred to the House Judiciary Committee.

House Bill 5095 — Reduce Judgments based on Insurance Benefits
Sponsor: Representative David Honigman — (R-W. Bloomfield)
This bill would allow for the reduction of judgments based on insurance benefits received for injury. Introduced 10/17/85. Referred to the House Judiciary Committee.

House Bill 5147 — Medical Malpractice Insurance/BCBSM
Sponsor: Representative Ernest Nash — (R-Dimondale)
This bill would allow Blue Cross and Blue Shield of Michigan to invest in medical malpractice insurance companies. Introduced 11/5/85. Referred to the House Insurance Committee.

House Bill 5148 — Casualty Insurance/Notice of Cancellations and Premium Increases
Sponsor: Representative Alvin Hoekman — (R-Holland)
This bill would require a ninety-day notice of nonrenewal, cancellation, or increase in premiums for casualty insurance. Introduced 11/5/85. Referred to the House Insurance Committee.

House Bill 5149 — Tort Judgments/Itemizing
Sponsor: Representative David Honigman — (R-W. Bloomfield)
This bill would require triers of fact to itemize judgments and settlements into past, future, economic, and noneconomic damages. Introduced 11/5/85. Referred to the House Judiciary Committee.

House Bill 5150 — Tort Actions/Venue
Sponsor: Representative John Strand — (R-Lapeer)
This bill would establish criteria for determining venue in tort actions. Introduced 11/5/85. Referred to the House Judiciary Committee.

House Bill 5151 — Periodic Payments of Future Damages
Sponsor: Representative John Strand — (R-Lapeer)
This bill would amend the Revised Judicature Act to provide for periodic payments of future damages over $250,000. The bill defines "future damages" and establishes mechanisms and procedures for periodic payment. Introduced 11/5/85. Referred to the House Judiciary Committee.

House Bill 5153 — Tort Judgments/Interest Rates
Sponsor: Representative Richard Bandstra — (R-Grand Rapids)
This bill would revise standards for paying interest on civil action judgments and requires the state to pay pre-judgment interest on judgments against

Continued on next page

it. Introduced 11/5/85. Referred to the House Judiciary Committee.

House Bill 5154 — Frivolous Lawsuits
Sponsor: Representative Richard Bandstra — (R-Grand Rapids)
This bill would provide for the awarding of costs and fees to the prevailing party in civil actions found by the court to be frivolous. Introduced 11/5/85. Referred to the House Judiciary Committee.

House Bill 5160 — Cancellation of Liability Policies
Sponsor: Representative Alvin Hoekman — (R-Holland)
This bill would amend the Insurance Code to specify conditions for cancellations of claims-made policies. Introduced 11/5/85. Referred to the House Insurance Committee.

House Bill 5162 — Joint and Several Liability/Collateral Sources
Sponsor: Representative Perry Bullard — (D-Ann Arbor)
This bill would amend the Revised Judicature Act by defining collateral sources and their admissibility and revising the doctrine of joint and several liability. Introduced 11/5/85. Referred to the House Judiciary Committee.

House Bill 5164 — Medical Malpractice Complaints
Sponsor: Representative Ernest Nash — (R-Dimondale)
This bill would require both the plaintiff and the defendant in a medical malpractice action to either post security of $2,000 to cover court and legal costs or file an affidavit containing an opinion from a medical expert that the party's claim or defense is meritorious. Introduced 11/7/85. Referred to the House Judiciary Committee.

House Bill 5165 — Medical Malpractice/Mediation Panels
Sponsor: Representative David Honigman — (R-W. Bloomfield)
This bill would require all medical malpractice claims to be submitted to mediation before trial; establishes procedures for administering mediation. Introduced 11/7/85. Referred to the House Judiciary Committee.

House Bill 5169 — Medical Malpractice/Expert Witnesses
Sponsor: Representative Debbie Stabenow — (D-Lansing)
This bill woud amend the Revised Judicature Act to define expert witnesses in medical malpractice cases, notification of defendants, and affidavits of non-involvement. Introduced 11/7/85. Referred to the House Judiciary Committee.

House Bill 5175 — Health Care Providers/Patient Records and Information
Sponsor: Representative Michael Bennane — (D-Detroit)
This bill would amend the Michigan Penal Code to prohibit a health professional licensee from falsifying or destroying a patient's records and from providing misleading information regarding a patient's treatment. Introduced 11/7/85. Referred to the House Judiciary Committee.

House Bill 5176 — Periodic Payments
Sponsor: Representative Perry Bullard — (D-Ann Arbor)
This bill would provide for the periodic payments of judgments in personal injury acions. Introduced 11/7/85. Referred to the House Judiciary Committee.

House Bill 5184 — Tie Rating Schedules to Risk Management Efforts
Sponsor: Representative Mary Brown — (D-Kalamazoo)
This bill would require the tie-rating schedules for commercial liability insurance to risk management efforts. Introduced 11/7/85. Referred to the House Insurance Committee.

House Bill 5185 — Limited Liability Insurers
Sponsor: Representative Mary Brown — (D-Kalamazoo)
This bill would authorize the formation of limited liability insurers. Introduced 11/7/85. Referred to the House Insurance Committee.

House Bill 5187 — State Liability Insurance Fund
Sponsor: Representative Lewis Dodak — (D-Montrose)
This bill, very similar to HB 5189, would add Chapter 17 to the Insurance Code creating a State Liability Insurance Fund. Introduced 11/7/85. Referred to the House Committee on Appropriations.

House Bill 5188 — Medical Malpractice Insurance Fund
Sponsor: Representative Matthew McNeely — (D-Detroit)
This bill would amend the Insurance Code by creating a medical malpractice insurance fund to be administered by its own governing board. The bill is essentially a reintroduciton of the Brown-McNeely Fund as amended in 1977. Introduced 11/7/85. Referred to the House Insurance Committee.

House Bill 5189 — State Liability Insurance Fund
Sponsor: Representative Matthew McNeely — (D-Detroit)
This bill, very similar to HB 5187, would add Chapter 17 to the Insurance Code creating a temporary State Liability Insurance Fund. Introduced 11/7/85. Referred to the House Insurance Committee.

House Bill 5192 — Mandatory Insurance
Sponsor: Representative William Keith — (D-Garden City)
This bill would provide for mandatory insurance for health care providers and require certification of coverage before being licensed as a physician, osteopathic physician, podiatrist or dentist. Introduced 11/12/85. Referred to the House Insurance Committee.☐

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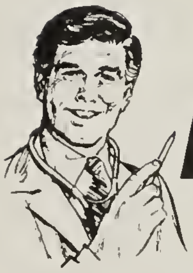

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These AMA reports are available

MSMS has copies of the following general interest reports adopted by the 1985 AMA House of Delegates meeting December 8-11 in Washington, DC. Contact the MSMS Department of Communications and Professional Relations to request them.

Report A of the Council on Scientific Affairs: Effects of Pesticide Exposure.

Report B of the Council on Scientific Affairs: Health Effects of Smokeless Tobacco.

Report C of the Council on Scientific Affairs: Antibiotics in Animal Feeds.

Report D of the Council on Scientific Affairs: Report of Panel on Lasers in Medicine and Surgery.

Report E of the Council on Scientific Affairs: Drugs and Athletes — Interim Report.

Informational Report of the Council on Scientific Affairs: AIDS Status Report — Prospects for Vaccines, Antiviral Agents, and Immunotherapies.

Informational Report of the Council on Scientific Affairs: Opioid Abuse and Dependence — Diagnosis, Referral and Treatment.

Informational Report of the Council of Scientific Affairs: Toxic Shock Syndrome.☐

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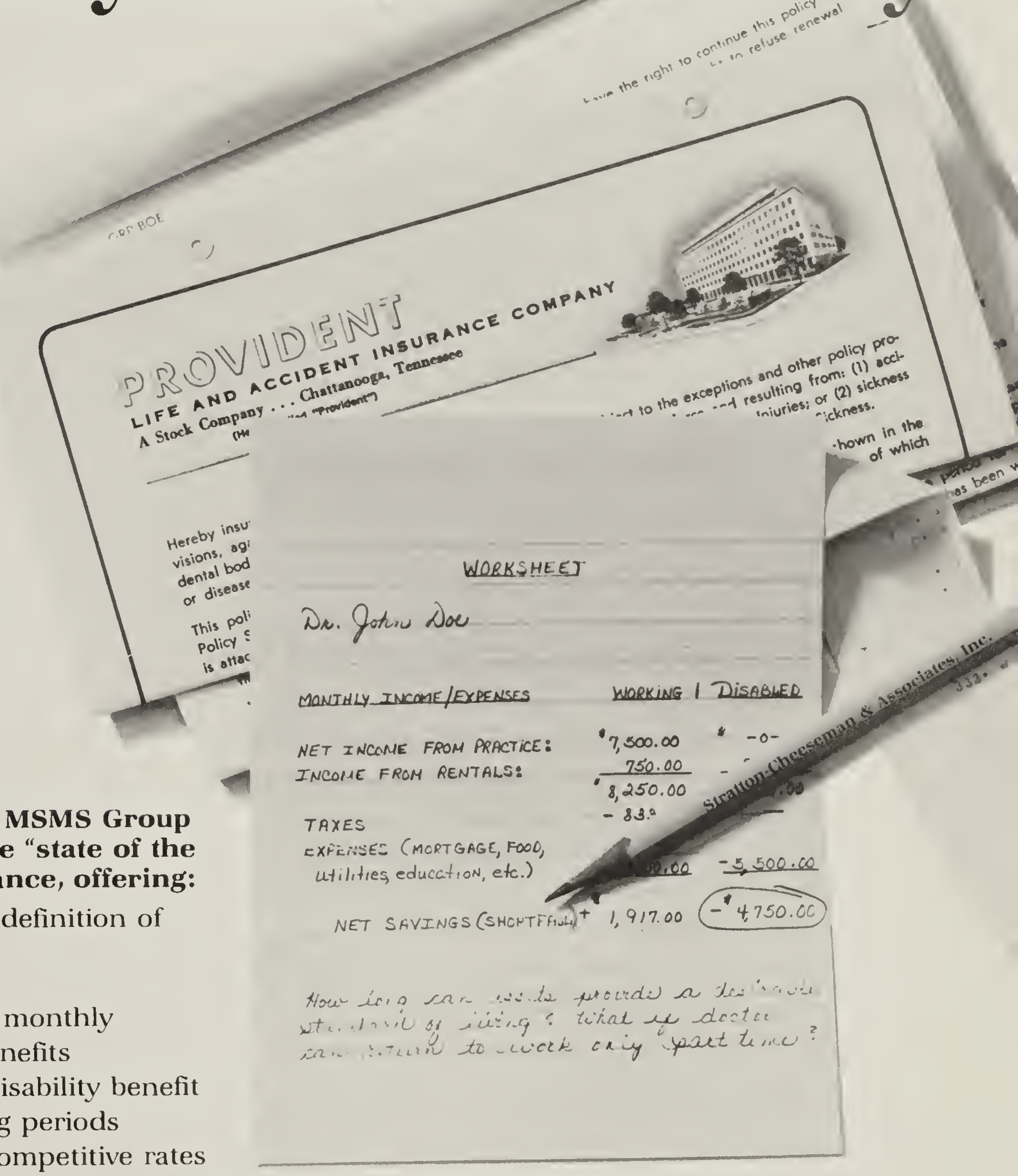
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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

Date: February 26, (plus five once-a-week sessions March 5,12,19,26,) Chemical Dependency. Location: Detroit. **Sponsor:** Fairlane Health Services Corp. **Contact:** Elaine Hughes, Fairlane Health Services Corp., One Parklane Blvd. Suite 1002-West, Dearborn 48126 (313)271-6502. **Approved for:** 3 hours of Category I Credit.

Date: March 12, Dermatology for Primary Care Physicians. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **Approved for:** 8 hours of Category I Credit.

Date: March 14-15, Third Annual Chronic Pain Symposium. Location: Florentine Inn, Saginaw. **Sponsor:** Bay Medical Education. **Contact:** Dodie Roth, Bay Medical Education, 615 Ninth Street, Bay City 48078. **Approved for:** 13 hours of Category I Credit.

Date: March 19, Critical Care and the Pulmonary Practitioner. Location: Kalamazoo Hilton Inn. **Sponsor:** Southwestern Michigan Area Health Education Center and Michigan State Respiratory Therapy. **Contact:** Judy Smith, Pulmonary Services, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001 (616)383-4875. **Approved for:** 5.5 hours of Category I Credit.

Date: April 7-9, Hemodynamic Monitoring and Management. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Dove Margenau, Towsley Center-Box 057, Ann Arbor 48109 (313)763-1400. **Approved for:** 14.25 hours of Category I Credit.

Date: April 10-11, Mechanical Ventilatory Support and Management. Sponsor: University of Michigan Medical School. **Contact:** Dove Margenau, Towsley Center-Box 057, Ann Arbor 48109 (313)763-1400. **Approved for:** 14 hours of Category I Credit.

Date: April 12, Geriatrics Symposium. Location: Mental Health Center, Bay City. **Sponsor:** Bay Medical Education. **Contact:** Dodie Roth, Bay Medical Education, 615 Ninth Street, Bay City 48708 (517)892-1501. **Approved for:** 6 hours of Category I Credit.

Date: April 16, Psych/Med Day. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital **Contact:** Carol Mastroianni, Program Coordinator (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: April 23, Cancer Prevention and Early Detection. Location: Genevieve U. & Donald S. Gilmore Center for Health Education, Healthcare Plaza, Kalamazoo. **Contact:** Charles L. Zeller, Jr., MD, SMAHEC, Stryker Center, 4th Floor, 1521 Gull Road, Kalamazoo 49001. **Approved for 6 hours of Category I Credit.**

Date: July 24-25, Collier Penberthy Thirlby Medical Conference. Location: Grand Traverse Resort, Grand Traverse Village. **Sponsor:** Munson Medical Center. **Contact:** Norma Powers, Coordinator of Medical Education, Munson Medical Center, 6th and Madison, Traverse City 49684 (616)922-9544. **Approved for:** 9 hours Category I Credit.

Date: September 3, Update '86—Rehabilitation of Traumatic Brain Injury. Location: Kalamazoo, Michigan. **Sponsor:** West Michigan Physiatry, PC and Southwestern Michigan Area Health Education Center. **Cost:** $50. **Contact:** Doctor Bryan Visser, West Michigan Physiatry, PC, 252 E. Lovell Street, Suite 363E, Kalamazoo 49007. **Approved for:** 5.75 hours of Category I Credit.

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By Joel I. Hamburger, MD

I didn't march

I didn't march. Maybe I should have. I did feel guilty when colleagues asked if I was going to march. Somehow the picture of a protesting, sign-carrying supplicant, seeking relief from the Legislature did not fit my image of a physician. To be sure, there was a feeling of fellowship, solidarity, and even pride among the participants. At last we were doing something, and doing it together! Our legislators got the message this time. But did they, and was it the only message, or even the *right* message?

We saw the "even-handed" media treatment prominently displaying the lame and halt alleged (and sometimes real) victims of malpractice. We saw and heard the shouted exchanges between health professionals and counter-demonstrators. We heard the snide remarks that it was too bad doctors had to suffer bus rides to Lansing while their Cadillacs and Mercedes sat in the garages of their luxurious suburban mansions. Was that our place? Must we "demonstrate that we can be capable politicians as well as physicians"? If so, did the march serve this end?

Was the Legislature impressed with the threat to the public welfare, or did they view our concern as self-serving? Did we convince anyone that it is not the doctors' problem, it is the patients' problem? Did they learn that doctors don't pay malpractice premiums, patients pay them? Do they understand, and do we, that it is not a one day problem, but a daily surcharge all patients pay to support an abusive legal system? Was this a descent from our traditional role as healers and teachers, dedicated to public service, or merely a logical extension of that role necessitatd by practical realities of the contemporary milieu? Was this a demonstration of strength, or a reflection of weakness and frustration with our inability to cope effectively with a threat to the viability of our profession? In the final analysis, can we realistically expect this kind of activity by physicians to produce more than a pacifier from the Legislature?

Alternatives

These are questions that disturb us all. But let us go beyond question to consider a few obvious alternatives.

Let MSMS provide us with an ongoing supply of literature for distribution in our offices to inform our patients of the adverse economic and health consequences implicit on the status quo. Let there be descriptions of simulated catastrophes foreseeable with a continuing contraction in supply of threatened specialists. The literature could include suggested forms of protest to be sent to the Legislature.

Let physicians, especially those with obscenely high premiums, segregate the malpractice component of their fees to be identified as what it is, a tax paid by all patients to support a few lawyers, with minimal trickle-down to the truly injured. Let this "lawyers" aid tax "be collected before any services are rendered. Let patients understand that if they don't like making contributions to the welfare of the legal profession, *they* can change it.

Flood of letters

Let us have a flood of letters from patients inundate the Legislature. Let outraged patients by the hundreds of thousands march in protest in Lansing every week. Let us educate patients that it is their problem, and how they can solve it. Indeed, let us engage in politics, but let us do it in the forum of our choosing, with those whose respect we have earned, with those who are being punished by a system that feeds off the misery of the truly injured and the harassment of the innocent.

Let us promote the concept of a patients' compensation fund for the truly injured. Awards could be handled administratively by a professional board which would pay fixed fees for specific injuries, payments to be made only to the patients. If patients chose to have legal counsel it would be their responsiblity to pay for it.

These and other ideas need discussion, expansion, and clarification. But our leaders have the requisite talent to devise effective and reasonable alternatives to the status quo, alternatives that do not hold the profession up for public ridicule or charges of self-interest. Let us present these alternatives to our patients, and let them carry the ball. It's their ball game.

Which place is our place? Do we march, or do we heal and teach?☐

Doctor Hamburger maintains a Southfield practice specializing in thyroid diseases.

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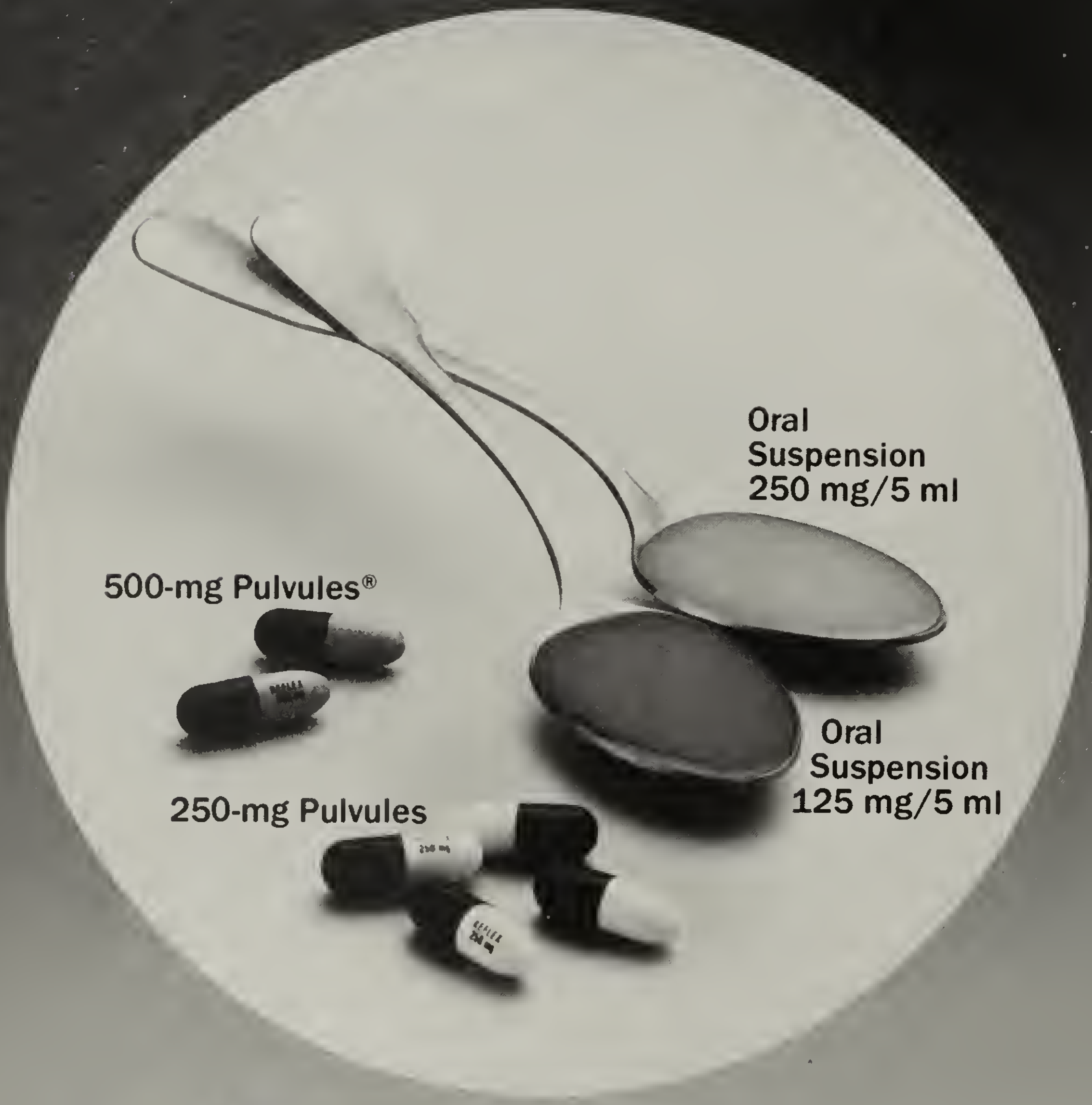
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DEATHS

Raphael Altman, MD
Southfield
Doctor Altman died November 17 at the age of 65. Born in Australia, Doctor Altman graduated from the U-M Medical School. He was former chief of surgery and chief of staff at Grace Hospital. Doctor Altman was also past president of the Academy of Surgery of Detroit.

G. Clare Bishop, MD
Almont
Doctor Bishop died November 4 at the age of 86. Doctor Bishop was a life-long resident of Almont where he practiced medicine for 60 years. He was the first Chief of Staff at Community Hospital at Almont. Doctor Bishop was a fellow of the American College of Surgery as well as the American Board of Surgery.

Philip D. Bonifer, Jr., MD
Battle Creek
Doctor Bonifer died October 26 at the age of 52. He graduated from the University of Marquette Medical School in 1959 and completed his ophthalmology residency at the University of Minnesota in 1964. Doctor Bonifer then returned to Battle Creek where he practiced for 20 years.

David E. Boswell, MD
Three Rivers
Doctor Boswell died October 24 at the age of 55. He graduated from Ohio State University Medical School in 1956. Doctor Boswell practiced in Marshall and Portage and in 1982 moved to Three Rivers where he owned and operated the Boswell Family Medical Practice.

William J. Coulter, MD
Drummond Island
Doctor Coulter died at age 77 on November 13. Doctor Coulter operated the Drummond Island clinic for 21 years. He had specialized in OB-GYN before taking over the island practice. Doctor Coulter had a life-long affiliation with the American College of Obstetrics and Gynecology and served on that group's board of directors.

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MEETINGS

MSMS, MSMS/A, AMA & MEDICAL ASSISTANTS

January 22 — MSMS Board of Directors Meeting, MSMS headquarters, East Lansing, contact: William Madigan (517)337-1351.

March 19-20 — MSMS Maternal Health Conference, "25 Years of Growth and Change", Hyatt-Regency Dearborn, contact: Sherry Fent, MSMS headquarters.

March 19 — MSMS Board of Directors Meeting, MSMS headquarters, East Lansing, contact: William Madigan (517) 337-1351.

April 11-13 — AMA's Seventh National Conference on the Impaired Physician, Hilton Hotel and Towers in Chicago, contact: Pat Clark, (312)645-4497.

May 2-4 — MSMS House of Delegates, Hyatt Regency Dearborn, contact: William Madigan (517)337-1351.

May 15 — MSMS Conference on Sports Medicine, Clarion Hotel (Long's), Lansing, contact: Sherry L. Fent, MSMS headquarters.

July 17-20 — MSMS Midsummer Board meeting, St. Clair Inn, St. Clair, contact: William Madigan (517)337-1351.

OTHER MEETINGS

March 19-22 — 1986 Great Lakes Athletic Trainers Association Winter Meeting and Sports Medicine Symposium, Amway Grand Plaza Hotel, Grand Rapids, contact: Lee Kermode, 2317 Gleneagle Drive, Kalamazoo 49001.

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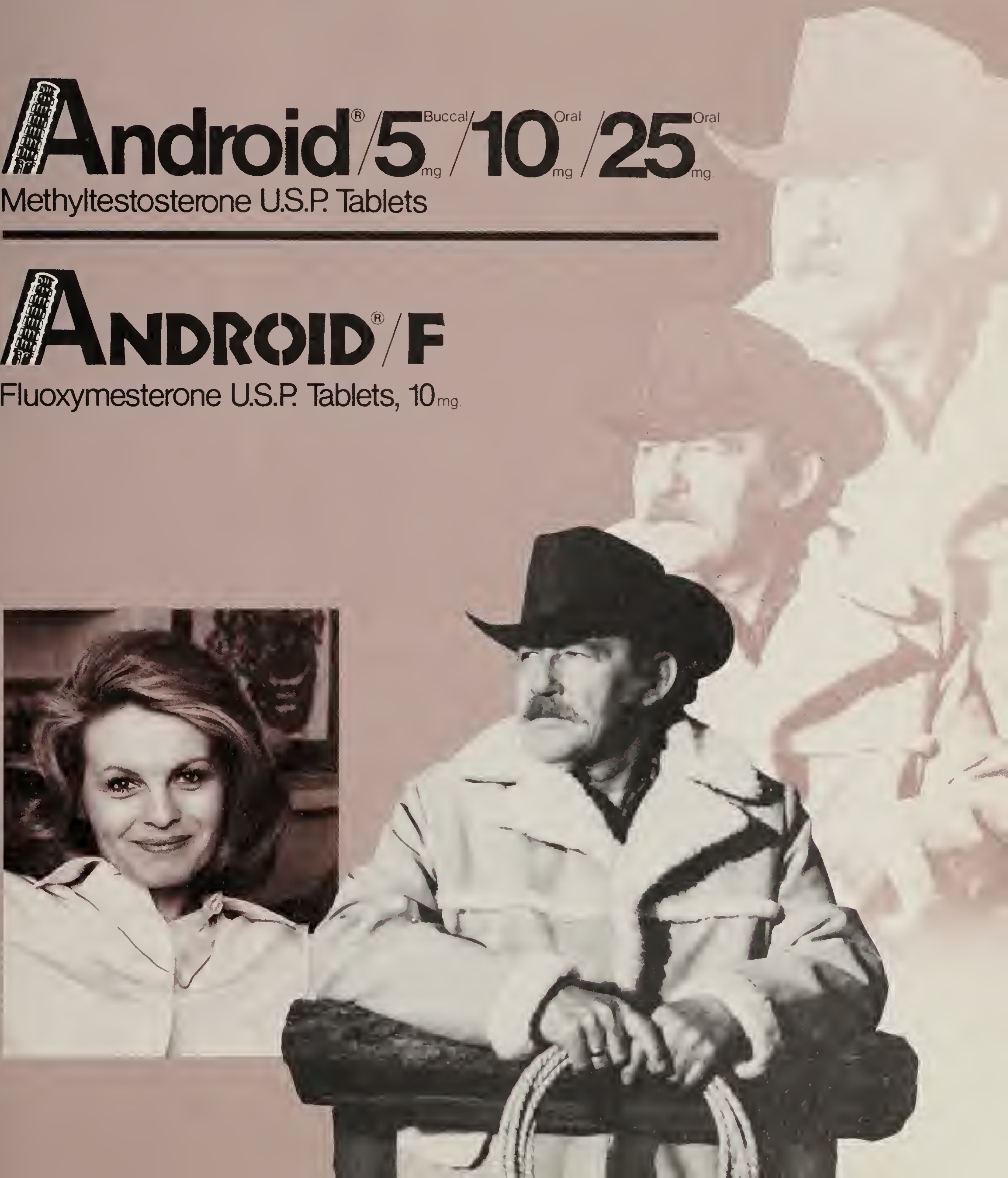

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By Richard J. McMurray, MI

MSMS has a proud history in maternal/perinatal health

Among the many MSMS-sponsored programs, the Michigan Conference on Maternal and Perinatal Health rates very high. The program committee has Co-chairmen this year, Robert Dustin, MD and Joe Metz, MD. They are putting together an excellent program designed for obstetricians, pediatricians and family practitioners. Be sure to put March 19-20, Hyatt Regency Dearborn on your calendar.

This conference has an interesting history, familiar to me, in that it originated in Flint, my hometown, and I have been more or less involved with the subject matter for the last 35 years.

In the late 1930s a foundation was established in Flint by William B. Knudson to honor his wife and her role as a mother, and to benefit Flint, where he got his early start with General Motors. The Clara Elizabeth Foundation was established to combat maternal mortality, so prevalent in Flint at that time.

Childbirth classes

This foundation stressed the importance of prenatal care and provided educational classes to all pregnant patients of the community, absolutely free of cost. It was the leading prenatal educational program in Michigan.

Under the able leadership of director David Treat the program expanded with fathers' classes and sex education classes in the schools and for community groups.

There was also a professional component which provided educational seminars for physicians and nurses interested in obstetrics and pediatrics. The conferences were very popular in the 1950s and were co-sponsored by the Michigan Society of Obstetricians and Gynecologists.

The Clara Elizabeth foundation had a "sunset clause" and was legally disbanded 25 years ago. Ralph Steffe, MD and Jack Thompson, MD, medical directors of the foundation (and former associates of mine) worked with the MSMS Maternal Health Committee and provided original funding for the establishment of the present Conference on Maternal and Perinatal Health.

The past 25 years has produced a great change in the practice of obstetrics. The original emphasis of preventing maternal deaths has now changed to that of lowering the infant mortality rate.

Probably the most significant change has been the identification of the high risk patient before and during pregnancy. We have become well aware of these concepts, yet even with today's sophisticated risk assessment techniques we miss one third of the women who eventually deliver high risk infants.

Perinatal services

The MSMS Maternal Health Committee promoted regionalization of perinatal services 10 to 12 years ago, along with the establishment of NICUs on a regional basis. This has been extremely successful in lowering the perinatal mortality rate in many areas of our state. Recognizing that good prenatal care leads to greater success against low birth weight infants, the state health department has created funding for this needed care for the medically indigent. I would like to promote the availability of this funding, because I understand that actual utilization has been somewhat disappointing.

Yes, we have come a long way these past 25 to 35 years. Continued improvements and progress are anticipated, but a dark cloud looms on the horizon — the lack of available manpower to care for the pregnant patient. The threat of litigation is forcing many of our well-trained and experienced obstetricians into early retirement or withdrawal from obstetrics. And residents finishing our excellent programs here in Michigan are forced to leave the state because they either can't obtain or afford malpractice insurance.

It is indeed sad that a discipline which has worked so hard to enhance the care of mothers and infants must now watch as these advances, so painstakingly developed, stagnate and possibly disintegrate because of lack of good professional care.

I invite all of you to inform your patients of this ongoing dilemma, and I invite you to attend the Michigan Conference on Maternal and Perinatal Health in Dearborn, March 19-20.□

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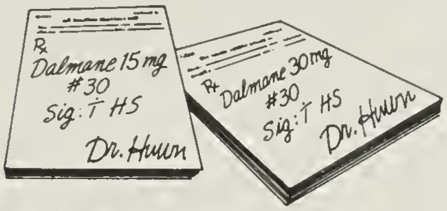

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MICHIGAN MEDICINE

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Computers in the medical office

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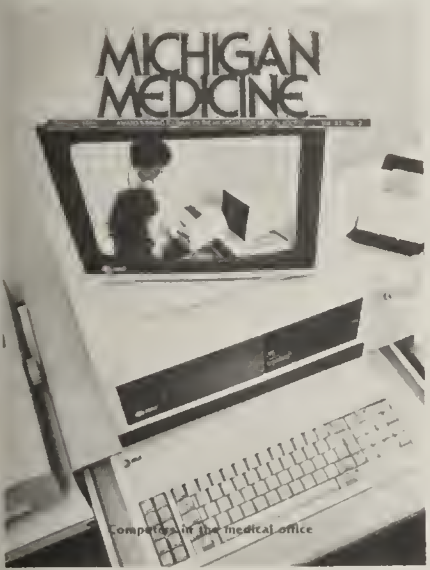

About the cover: Computer hardware and software can enhance productivity, efficiency in the medical office. **Photo by Kim Kauffman.**

Special report

38 Deciding whether or not to computerize your medical office can be a tough decision — many factors have to be considered. Every practice is different, as is every computer hardware and software package. To end up with a good "marriage," decision-makers must consider the particulars: practice size, billing needs, staff arrangements and more. This month's Special Report will help you make informed choices; Garry S. Kolb, Coral MacKenzie and Ellen Vinocur Potash.

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Toward a more equitable system

Shearer

As I reflect on the past year's efforts toward correcting the professional liability situation—Professor Fleming's report, the press' slanted reporting of his recommendations, the wonderful turnout and exemplary professional decorum at "The Rally" and the innumerable hours of physician time involved—I feel deeply thankful to those physicians who give so generously of their time and expertise in furthering efforts to make the system more equitable for all.

As the incidence of litigation escalates, I wonder how medical students and residents could best be trained for their possible involvement in medical-legal encounters. Certainly didactic training in these aspects of the practice of medicine were minimal during my education.

As we continue to pursue the solutions to problems that beset us, critical consideration could well be directed toward some type of peer review mechanism for medical testimony similar to the standards of peer review applicable in medicine. MSMS has repeatedly supported proposals which would re-define an "expert" in a given medical area. Perhaps "experts" should be utilized as advocates of the truth—at the disposal of the court—rather than as advocates for the prosecution or the defense.

As responsible, honest people striving to benefit our patients and our honored profession, it behooves us to continue to direct our energies and careful consideration toward achieving an atmosphere that is non-adversarial between doctor and patient.☐

Doctor Shearer, Dexter, is a member of the MSMS Committee on Publications.

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Support for "Star Wars"

This letter was received by Carl A. Gagliardi, MD, chairman, MSMS Board of Directors.

This letter is in opposition to he article by Michael J. Miller, MD, for the Detroit Physicians or Social Responsibility in "Views" of *Michigan Medicine*, December, 1985. While no civilized person can fail to be opposed to nuclear war, I must reject the Soviet-style program of "peace through medicine."

It is naive to think that to stop testing of nuclear weapons will do anything to decrease the threat of their use. The Russian counterparts of these "Physicians for Social Responsibility" are using this group to further Russian imperialism. The arguments used against the Strategic Defense nitiative are cynically deceptive in view of the fact that the Soviets already have a similar program nearly ready for deployment.

The SDI is not nuclear and is purely defensive and thus makes nuclear weapons obsolete. I am unable to understand how any informed person could be opposed to a weapons system which is only capable of destroying nuclear missiles in their launch pads or shortly after launch. What these people are asking us to do is to set Western Civilization up for nuclear blackmail by the Soviets and their continuous appetite for conquest. These people are advocating the "peace" of Poland, East Germany, Cuba, Angola and Afghanistan, to name just a few and I, for one, feel that their doctrine has no place in a medical journal, at least not this side of Moscow.

Edward S. Bernreuter, MD
Saginaw

Doctor Miller responds:

Thank you for the opportunity to respond to Doctor Bernreuter's letter. I must take exception to several assertions.

I believe that continued testing of nuclear weapons *does* logically increase the threat of their use, and only perpetuates the endless talk-test-build cycle that has gotten us into the present stalemate. The Soviet version of Strategic Defense Initiative is not "nearly ready for deployment," but also in an early R & D phase of development. While the SDI program is indeed planned as a defensive system, it is partly nuclear, in that its favored technology, the X-ray laser, depends upon the instant conversion of energy from a nuclear explosion to a focused beam of x-rays.

The insistence on testing this weapon has stymied any significant results from the Geneva Arms Talks. The suggestion of destroying missiles on their launch pads *is* a first strike! The alternative of destroying them in their boost phase with space-based weapons is exactly the problem that the Union of Concerned Scientists (including 36 Nobel Laureates) have determined to be impossible in the book *The Fallacy of Star Wars.*

There is no fool-proof defense from offensive ballistic missiles that cannot somehow be circumvented, given enough time and money. The continued quest for such a perfect system will necessarily effect physicians by diverting much-needed funds from programs which could improve the quality of medical care, especially in underserved areas. More importantly, recent attempts by the Administration to cut back on the National Institutes of Health budget, and thereby inhibit crucial biomedical research, are much more of a direct threat to the quality of care for every single American.

Michael J. Miller, MD
Detroit Physicians for
Social Responsibility

Considering a computer?

Physicians looking for a computer for their office might take some tips from Ellen Vincour Potash.

"Somehow you've got to figure out what you want and need," Potash told approximately 50 physicians and office staff members present for a seminar at the Amway Grand Plaza Hotel in downtown Grand Rapids.

A needs assessment logically includes comparing present office operations to computerized methods. Potash said such an assessment must take into account the following:

- the number of active patients;
- the number of inactive patients;
- the number of visits per patient per month;
- the number of physicians and/or other health professionals;
- staffing the practice;
- the number of statements per month;
- the number of insurance forms processed per month;
- the amount of word processing that would be done on a computer.

Areas that can be computerized include patient billing, insurance processing, daily listings of charges and services, applications, management reports, accounts receivable aging, productivity analyses, income statements and balance sheets, patient scheduling, referral sources from physicians, payroll, statistical reporting on patients, demographic data on patients, clinical applications, medications profiles, word processing, medical records (Potash acknowledges that by law medical records must be paper recorded but said computer files for quick reference are a plus) and patient recall lists. A computer

---

Coral MacKenzie is a free-lance writer in Grand Rapids.

By Coral MacKenzie

lso can be used for patient ducation, and for marketing pplications such as sending reeting cards or friendly notes o patients, prospective atients and staff members.

Hardware and software

As Potash says, "there is no software package on the face of this earth that will satisfy all of your needs." But obviously the computer can do an enormous amount of work. It's up to the physician to decide how much work should be computerized, and that involves deciding how much should be and can be invested in hardware and software.

Among the things that must be weighed when deciding to purchase a particular computer package are whether the software does Michigan billing, the number of terminals needed in the office, even the noise level of the printer.

When talking with sales vendors about packages, physicians would be wise to take notes, in part to have a backup when a proposal is made, Potash said. Think in terms of the future of the office practice. If tremendous growth is a clear possibility, look at systems that can accomodate hardware expansion, she said.

If the investment is to be truly beneficial to the physician, the vendor must work idiosyncrasies of the office operation into the system. "If the physician doesn't have time to go over details with the vendor, the office staff *must*, Potash said, but "at some point the physician has got to get involved because the physician is the ultimate decision-maker."

The physical layout of the office and furniture for the hardware are other considerations. The depth of existing work areas must be measured to assure that the hardware will fit appropriately. If a keyboard is not at typing height for a particular employee, backaches and other problems could result.

Toward efficiency

Clearly, financial investment is not the only investment in buying a computer. An evaluation of the present mode of operation versus new ways introduced by the computer will insure a resulting office system of the greatest efficiency. It's quite probable, Potash said, that some methods of operation will be completely changed — for the better.

Once the computer system is in the office, consider the office personnel. Vendors can teach the physician how to help staff through the conversion process, which Potash said takes at least three months. Options in dealing with the conversion process include hiring temporary help to plug information into the computer or to help run the office while the permanent employees work with the computer. Potash stresses that employees *must* learn to use the computer once it is in the office, however having temporary help will avoid overload. "No way can you double the workload and have happy people," Potash said.

The physician is well-advised to anticipate some computer fears on the part of employees, Potash said. "You can expect that some office workers will be unhappy. Many worry that they will be replaced by the computer. Remind employees that the computer needs a human being to run it."

Once the computer has been in the office a month, discrepancies between the program and the office operation should be handled, Potash said. After the second month, the two modes of operation should be completely reconciled. If there still are discrepancies, dual systems should be continued.

After carefully weighing the pros and cons of a computer system for the office, a physician should have a clear idea of whether or not such an investment of time and money is worth it. Potash advises physicians to make a decision based on well-researched information on both the office operation and on a prospective computer system. ☐

By Ellen Vinocur Potas

Selecting a medical office computer system

Potash

Computers can offer the medical office important opportunities to improve productivity and enhance the business operation of the practice. However, choosing the appropriate hardware and software can provide a considerable challenge. Most physicians and/or office personnel have little or no experience with computer information systems and often are unable to effectively evaluate the myriad packages available today.

A physician may think about computerizing the office for many reasons: a large volume of paperwork; difficulty in collecting outstanding receivables or tracking patient information.

It is necessary for the office staff to do a thorough practice evaluation in order to determine whether computerization would be of value. This article offers suggestions for doing a practice evaluation as well as pointers on the selection of a computer system for your office.

Define practice needs

One of the easiest ways to define practice needs is to have every member of the office staff develop a "wish list." Each "wish" should be specifically itemized and further defined by stating the reason for the need, its significance, the method currently employed to accomplish the task and how a computer would accomplish it.

Let's look at insurance claims processing (the defined need) as an example. Much time is spent preparing forms by hand. Insurance claims must be done quickly to insure prompt reimbursement, the patient information (name, address, etc.) must be transcribed from the patient encounter form to each insurance claim and the volume of paper processed is enormous. A computer would keep the basic patient information and each day's transactions would be added to it. In addition, the computer would print the forms automatically in a "batch job" and the staff person would simply supervise the printer. The computer might prepare the forms for electronic transmission.

Let's say that more than 200 claims are processed per month. Each claim requires at least fifteen minutes to complete—therefore, 50 person hours are used for the task each month. The number of staff hours multiplied by the hourly wage of the employee equals the actual dollar cost to the practice. Now, write down the steps currently used to manually process the claims and compare these to the computer automated process.

At the conclusion of your written evaluation, review the data and determine whether each need is a *perceived* one or a *real* one. In the above example, it is certain that a computer would handle the insurance claims processing more quickly than the current manual operation. Moreover, the number of claims processed indicates that this is a *real* need.

If however, the office processed only thirty insurance claims per month, the staff time used (7.5 hours) would hardly warrant the expense of a computer. Therefore, this might be considered a *perceived* need rather than a *real* need. Of course, one must consider how many other tasks are required of the same staff member. If the office employs a single staff person who is asked to do everything, a computer might streamline office procedures considerably.

Prioritize your needs

Organizing your needs in order of importance is essential to evaluating the various software packages available. Most packages probably will do insurance claims processing and statement generation, etc., but each package has different "bells and whistles." Be prepared to look at the various functions of each software program as they relate to the prioritized needs of the office.

You may wonder why the software evaluation comes before the selection of the computer (the hardware). Pur-

Continued on page 42

Other computer considerations

Hardware maintenance: There should be a monthly charge for hardware maintenance which guarantees that mechanical problems will be handled (preferably) within one working day. Some vendors provide for a loaner unit which can be used when your hardware is inoperable. As with any equipment purchase, you can expect that sooner or later you may have some problems. If for some reason you have purchased your computer equipment from someone other than the provider of the medical software, find out if the software vendor will provide hardware maintenance as well. It is much easier to deal with a single service provider.

Software maintenance: Software maintenance contracts include troubleshooting problems that may develop when running your medical package. A contract also guarantees that the office will be provided with updates to the package at no additional charge.

Training: Some vendors provide training on the hardware and software as part of the original purchase price. Others will have a separate charge for training. Find out how many hours of training are provided, whether this time will be spent at your site or at another site, how much post-installation support will be provided and whether such support will be in-person or by telephone. A great deal of support can be offered over the telephone once the initial installation and training time has been completed.

Vendor reputation: Ask for references from the salesman and have someone in the office check those references. Ask questions about promptness of service, degree of helpfulness after the sale and satisfaction with the operation of the computer program itself.☐

chasing the hardware first may cause some difficulties: all too often, a computer store may sell a physician a computer "guaranteed to run the office."

In addition to hardware, the store may advise the physician to buy a word processor, a spreadsheet (financial management program) and some type of data base management software. The salesperson will no doubt indicate that, with very little effort, the physician then will be able to computerize all office functions.

However, independent software programs require more than a little expertise to operate. It also is possible that the storage capacity of the hardware purchased will not be adequate to handle a specialized program.

In general, it is best to find the software you want and then determine what hardware it runs on.

Management professionals advise that physicians select integrated packages: that is, select a medical management package that will handle accounting, insurance processing, office billing, produce practice management reports and so on. The best packages will be found through companies which specialize in medical office programs. Michigan physicians must be certain that the program purchased will handle the peculiarities of Michigan insurance billing. "Off-the-shelf medical software" (that is, a package that is not specifically configured for Michigan billing) will not work in Michigan without extensive modification.

When evaluating software packages, remember that no *one* program will meet every need exactly as defined. That is why it is imperative to prioritize office needs. Compare the operation of the software programs to current manual operation. (It is possible that the current process is just as efficient as the computer.) It also is possible that the computer would manage the process efficiently, but in a way that differs from your current operation. At that point, decide which is more important—the process or the product.

You may discover that current office operations are not as efficient as they might be. Remember, computerize an inefficient office and the result will be computerized inefficiency!

YUCK!
ENGLEMAN

"I just formatted the computer for the new 17-page insurance forms."

Research

Read the written material offered by the vendor. Look at the software training manual to see if it is easily read and understood. Next, see a software demonstration. Sit down and use the computer yourself *and* have the vendor demonstrate the product. It's wise for the physician and the office personnel to take notes during the demonstration. Communicate your particular needs to the salesperson and ask for examples of how the computer program handles them.

It is *imperative* that you set aside adequate time to hear the entire presentation.

The salesperson will discuss hardware options. Based upon the previous analysis of your office, you should have some idea of the number of work stations and printers that you want. Let the salesperson make a proposal and compare it to your own assessment. If the two vary widely, ask for an explanation. Be fair and communicate your needs clearly and accurately.☐

By Garry S. Kolb

Taming computer jargon

port
ROM
Peripheral
64k
diskette
RAM
Operating System

RAM, ROM, kilobyte, 64k, hard disk, floppy, 20MB. Do these words mean anything to you, or are they only so much computer mumbo jumbo? If you are considering purchasing a computer for either home or office use, these terms are critical to making an informed decision.

When you learn the basic computer lingo, computer salespeople no longer are intimidating, people using only technical buzz words, but become useful resources. Computer literature, too, will become understandable decision-making information. The biggest advantage of becoming computer literate is the transformation of computers from strange magic boxes to useful tools for medical office management, home finance, education and entertainment.

The following is a list of frequently used computer terms:

Application software: Programs which perform one or more functions. Generally available application software includes word processing, spread sheets, office management packages, graphics and data base management. These commonly are referred to as applications.

BASIC: Beginners All-Purpose Symbolic Instruction Code. BASIC is a computer language available for most micro-computer systems. It is very easy to learn and use, but also contains more advanced features for the experienced programmer. Other available programming languages include PASCAL, COBOL, FORTRAN AND C.

Bit: The smallest piece of information stored in a computer. A bit has only two states, on or off. In general, no micro-computer literature refers to bits.

Byte: The smallest addressable piece of information in a micro-computer. A byte consists of eight bits. Computer memory and storage is usually expressed in bytes. (See Kilobyte and Megabyte.)

Cathode ray tube (CRT): A CRT essentially is a television picture tube. Some computers come with their own CRTs. Others require purchase of a separate CRT, while still others may be attached to a home television. CRTs also are commonly called monitors.

Central processing unit (CPU): The CPU is responsible

Continued on next page

for all the computing in a computer. It retrieves all program instructions and executes them.

Compatible: Like people, all computers operate slightly differently. If a machine is advertised to be compatible to another, it means that programs written for the other machine also should work on the advertised machine. For example, if Super Duper Data Company advertises the SDDC 2000 as an IBM compatible machine, any program written for the IBM PC should also work on the SDDC 2000.

Diskette/disk: There are two forms of disks. The first is the diskette, or floppy diskette. This is a magnetic storage media capable of holding programs or any other information. Floppy diskettes can be easily removed and transported. A newer development for personal computers is the hard disk. Unlike the floppy, a hard disk is fixed inside the computer and may not be removed. Hard disks (or fixed disks) hold considerably more than do floppies. (See Kilobyte and Megabyte.)

Hard copy: Aren't words invented for one particular industry annoying? Hard copy means printed output. (The airline industry is the same way. When a person gets off a plane, he/she deplanes. Who debuses or deautos?)

Kilobyte: A kilobyte is 1,024 bytes. Generally abbreviated "K" or "KB," kilobytes are used to describe memory size, program size and floppy disk capacity. A 360K floppy disk can hold 360 x 1024 bytes, or 368,640 bytes of information. It takes about 2K to store a typewritten page. (See Megabyte.)

Megabyte: A megabyte is 1,000,000 bytes. Megabyte is abbreviated "M" or "MB." Hard disks generally can hold 10MB or 20MB (or more in professional systems). Some newer floppy diskettes can hold 1.2MB, or 1,200,000 bytes. A 1.2MB diskette can hold as much as can 3¼ 360KB diskettes. (See Kilobyte.)

Operating
System
ROM
diskette
port
RAM
Peripheral
64k

Operating system: The operating system is the program which controls all functions of the computer. Some popular operating systems are MS-DOS, CP/M and UNIX. In general, a computer will run only one operating system, but some newer models allow a choice of operating systems.

Peripheral: An adjective describing any accessory which attaches to a computer, such as a printer or monitor. It has come to be used in "computerese" as a noun, as in "the peripherals with the system include..."

Port: A connector on the back of the central processing unit used to attach peripherals.

Printer: There are three kind of printers to consider: The first is a letter-quality printer. Letter-quality printers produce very sharp print, like a typewriter, by using a daisy wheel print system. They also are the slowest type of printer A near-letter-quality printer produces good quality type (not as good as a letter-quality printer) and is faster. The fastest printer for general use is a draft-quality printer. The print is easily read, but hardly good enough for correspondence. Near-letter-quality and draft-quality printers use a dot matrix print method. Some of the newer dot matrix printers allow two-speed operation for near-letter-quality or draft printing.

RAM: Random Access Memory. Usually expressed in kilobytes, the amount of RAM determines the size of programs which will be allowed to run in the computer. A 256KB machine will allow a program of up to 256 x 1,024 or 252,144 bytes to run.

ROM: Read Only Memory. Programs included in the computer (not on floppy diskettes) reside in ROM. ROM cannot be changed by the user, but programs in ROM can be run by the user.

Wonderful: How you will feel working on your computer system.

Armed with this information, you will not be fooled when someone tries to sell you a 512K bit machine for more money than a 64KB machine. (Remember that KB means kilobyte or 1,024 bytes. Also remember that a byte is eight bits. Than means a 512K bit machine is the same as a 64KB machine! 512 x 1,024 equals 524,288 **bits**. 524,288 **bits** divided by eight equals 65,536 **bytes** or 64KB!)

Remember, if you don't understand, ask! Questions are free. If you don't get an answer that you understand, go elsewhere—make an informed choice. Happy computing!☐

She's counting on You

And you have the talents
and skills to justify her
trust. Don't let alcohol
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The Michigan Program to
Assist Impaired Physicians
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Michigan State Medical Society
Michigan Association of
Osteopathic Physicians and Surgeons
PO Box 950, East Lansing, Michigan 48823
Contact: Katie Brewbaker
Phone (517) 337-1351

By Sheri W. Greenhoe
Managing Edito

Maternal Health Conference speakers reflect as well as look ahead

"Twenty-five years of growth and change" is the theme for next month's silver anniversary Conference on Maternal and Perinatal Health.

It's a loaded theme — maternal and perinatal health care has experienced an *explosion* of growth and change since the first conference in 1962. This year two dozen experts will explain and explore those advances March 19-20 at the Hyatt Regency Dearborn.

Many subspecialties will be represented on the conference faculty, and topics will include genetics, nutrition, infections, prematurity, neonatal diagnosis and hypertension, among others. (For program details, see the January, 1986 issue of *Michigan Medicine*, or contact Sherry Fent at MSMS headquarters.)

Several out-of-state speakers are scheduled, including Mona Shangold, MD, Assistant Professor, Department of Obstetrics and Gynecology and Director, Sports Gynecology Center, Georgetown University School of Medicine, Washington, DC; Alistair G. S. Philip, MD, Professor of Pediatrics, University of Vermont College of Medicine and Director, Division of Neonatology, Maine Medical Center, Portland; and Michael Katz, MD, Assistant Professor, Department of Obstetrics and Gynecology, Children's Hospital and the University of California, San Francisco.

Those three speakers shared their thoughts about strides made in maternal and perinatal health over the past 25 years. And they looked toward the challenges that face health care providers in the next quarter century.

A very important breakthrough, according to Doctor Shangold, is affirmation that "pregnant women should become fit *before* they become pregnant." The challenge then is to answer the question, "how much exercise is safe during pregnancy?"

Doctor Shangold is optimistic about the future in that expectant mothers are paying more attention to exercise and nutrition. "Hopefully," she says, "they will pay a lot more attention to this before pregnancy, too."

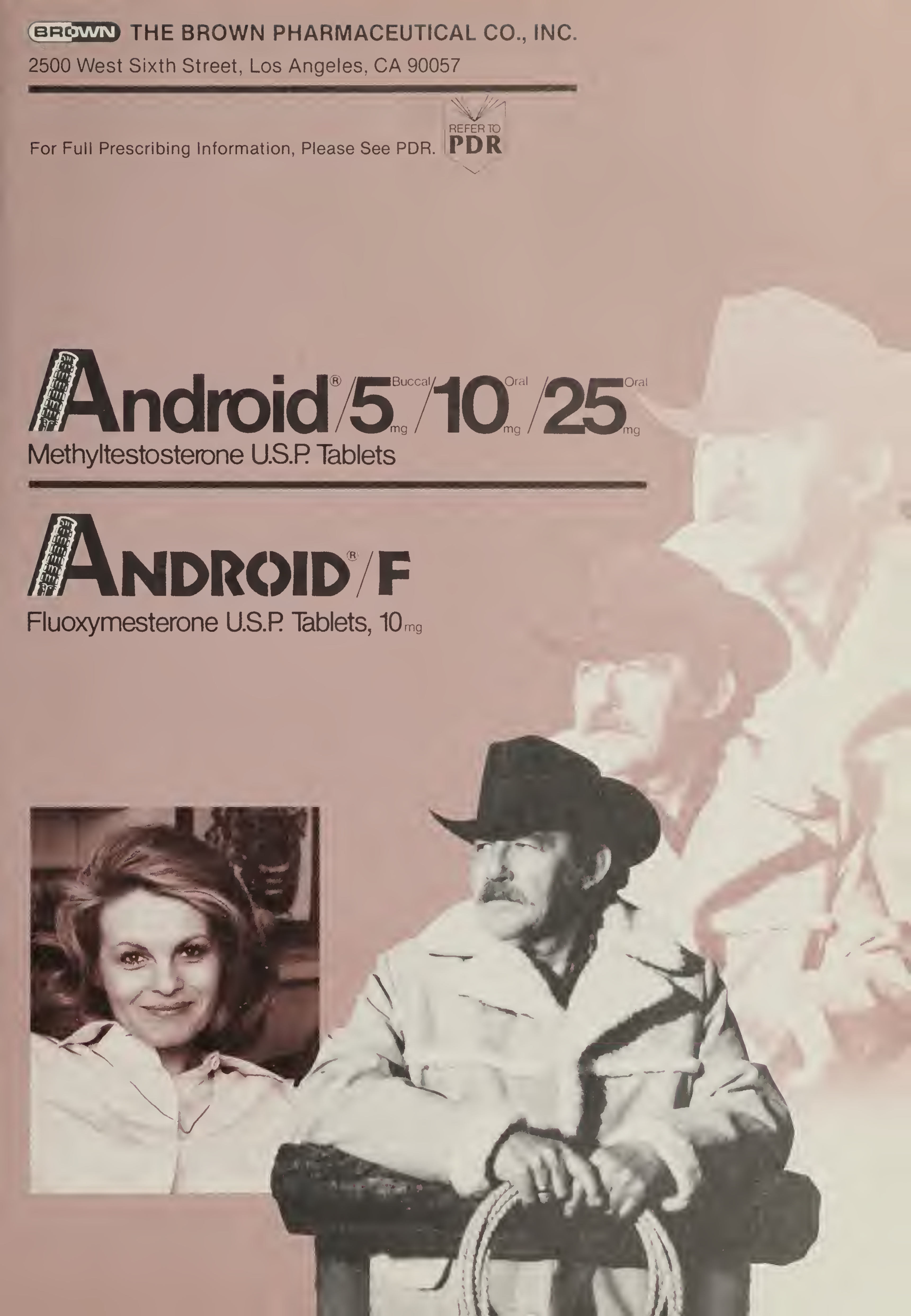
Improvements in antenatal diagnostics have been among the greatest boons since 1962 according to Doctor Katz. Today's health care providers have access to improved techniques for fetal evaluation during labor and for intensive care of the newborn.

During the next 25 years efforts should "shift from the treatment of morbidity to the prevention of morbidity," says Doctor Katz. "We should, for example, take the focus away from the treatment of prematurity and redirect it to the prevention of premature birth."

Doctor Philip concurs, and admits that "we have a long way to go in that regard." Future efforts should be directed at decreasing the number of low birth weight babies, he says.

A major change, but something we now tend to take for granted, is the use of RhoGAM for Rh incompatibility. "It has virtually wiped out that sensitization," says Doctor Philip. Another advancement he points to is the increased use of the respirator, which has made way for non-invasive transcutaneous blood gas measurement.

Surely these conference speakers and all the others could name more advancements in the field of maternal and perinatal health than would fit in this journal. And a list of the challenges ahead could fill volumes. The 1986 Michigan Conference on Maternal and Perinatal Health will explore a timely cross-section of these subjects. Contact MSMS for details. ☐



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Here are physician advertising guidelines

This voluntary code on physician advertising was adopted by the MSMS Judicial Commission September 15, 1982 and revised July 10, 1985. The Judicial Commission at a recent meeting instructed that the AMA ethical statement on advertising be published in *Michigan Medicine:*

The Judicial Commission of the Michigan State Medical Society recognizes that the US Supreme Court rulings and the written opinion of the Michigan Attorney General make it permissible for physicians to advertise the availability of their services, so long as the advertisements do not contain false, misleading, or deceptive material.

Because of these rulings the Judicial Commission offers the following information with the intention of providing guidelines for members of the Michigan State Medical Society who choose to advertise. The use of these guidelines is entirely voluntary on the part of any individual physician.*

It is appropriate to advertise the availability of physicians' services in the public media, at the location where such professional services are rendered, or by the issuance of business or appointment cards.

Public media include any commercial publications or other means of communication with the public, including newspapers, magazines, telephone directories, radio, television, or other advertising.

When using electronic media, remember the impressions perceived are often fleeting and misinterpreted. Thus it is suggested and recommended that this type of advertising should be prerecorded and approved by the practitioner. A recording of the actual transmission should be retained by the practitioner.

Advertisements are expected to be in good taste. If physicians have any concern as to propriety of a proposed advertisement, they are urged to consult with the appropriate officers and committees of their local medical society.

It is recommended that professional advertising provide:

- General information such as name, title, home and office address, telephone numbers, answering service, office hours and changes in office hours, absence from or return to practice, and additions to or deletions from professional license staff.
- Professional information such as degrees earned, board certification, areas of specialization, limitation of professional practice, type of practice, professional affiliation, hospital affiliation, and foreign language competence.
- Fee information such as usual and customary fees for routine professional services, notification that fees may be adjusted due to complications or unforeseen circumstances, and what third party payers are recognized.

It is considered inappropriate for a physician to engage in advertising relating to:

- Testimonials and/or anecdotal reports of successes by the practitioner, or claims of superior quality of care to entice the public.
- Fee comparisons with other practitioners licensed under the medical practice act.

Physicians should not engage in:

- Advertising professional services which the practitioner is not licensed to perform.
- Advertising which contains false, fraudulent, deceptive, or misleading material, warranties or guarantees of success. ☐

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*A physician may provide medical services to members of a prepaid medical care plan or to members of a health maintenance organization which seeks members or subscribers through advertising. Physicians practicing in prepaid plans or as a member of a group such as an HMO, PPA, etc., are subject to the same ethical principles as are other physicians. Advertising which would lead prospective members or subscribers to believe that the services of a named physician who has a reputation for outstanding skill would be routinely available to all members or subscribers, if in fact this is not so, is deceptive. However, the publication by name of the roster of physicians who provide services to members, the type of practice in which each is engaged, biographical and other relevant information is not a deceptive practice.

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AN APPOINTMENT
WITH THE
DOCTOR"
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CANCER

Be prepared, Doctor. More patients will be asking about colorectal cancer. According to a survey* conducted by the American Cancer Society, many people would like to receive more information about colorectal cancer, and 83% said they would want to be checked for it. Further, they are learning that this cancer can be detected *before* symptoms appear. The present cure rate is 44%. The cure rate *could* be as high as 75%, with early detection and appropriate management.

For asymptomatic persons the Society recommends annual digital rectal examination at age 40 and over; at age 50 and over, an annual stool blood test, as well as sigmoidoscopy every three to five years, following two initial annual negative sigmoidoscopies.

We're here to help. You can reach us at your local American Cancer Society office or write to our Professional Education Department at National Headquarters, 90 Park Avenue, New York, N.Y. 10016. Ask about the Society's Colorectal Check program of professional and public education for the early detection of colorectal cancer.

AMERICAN
CANCER
SOCIETY®

*"Cancer of the Colon and Rectum: Summary of Public Attitude Survey," *Ca* 33:359-365, 1983 (Nov.-Dec.).

Medical Alert

®

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Thomas E. Stone, MD, Chairman, MDPAC

BALANCED CALCIUM CHANNEL BLOCKADE!

CARDIZEM
(diltiazem HCl)
balances potent coronary vasodilation with a low incidence of side effects

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page. 2/84

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

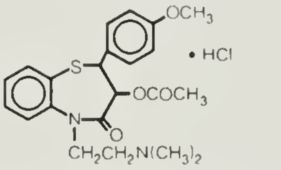
References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways.

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given, a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality These doses, in some studies, have been reported to cause skeletal abnormalities In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1 3% asthenia (1.2%), AV block (1 1%). In addition, the following event were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure syncope.
Nervous System:	Paresthesia, nervousness, somnolence tremor, insomnia, hallucinations, and amnesia
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting mild elevations of alkaline phosphatase, SGOT SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes o vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

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19110 Arrowhead Lane
Big Rapids 49307

R. D. Albertson, III, MD—IM/PUD
500 Lansing Ave.
ackson 49201

T. J. Alexander, MD—GE/IM
1955 Golfview # 206
Troy 48084

Yong S. Chung, MD—AN
302 Kensington
Flint 48502

B. B. Ganatra, MD—N/IM
G-3239 Beecher Rd.
Flint 48504

Roy S. Goodman, MD—OTO
36300 Van Dyke
Sterling Heights 48077

Thomas L. Haynes, MD—EM
107 Elsinore Lane
Battle Creek 48017

Steven M. Hudock, MD—FP
36157 Acton
Mt. Clemens 48043

Raphael J. Kiel, MD—IM/ID
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Birmingham 48010

Brian J. Kosiak, MD—OBG
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Saginaw 48602

Warren F. Lanphear, MD—EM
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Belding 48809

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Grand Rapid 49506

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Joseph R. O'Donnell, MD—NS
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Grand Rapids 49503

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Pontiac 48053

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Rochester 48063

Marta E. Rionda, MD—PTH
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Haslett 48840

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22631 Greater Mack
St. Clair Shores 48080

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Detroit 48202

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Holland 49423

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Northville 48167

Mitchell Urban, MD—FP
3501 Willis
Ypsilanti 48197

Ethel L. Villanueva, MD—PD
36410 Garfield
Fraser 48026

Gregory J. Waters, MD—AN
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Grand Rapids 49503

Susan L. Wainwright, MD—P
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Update on health-related legislation

Reprinted from the December 3 *GRA SHEET* (*MSMS* Government Relations Agenda). For further information contact Kevin Kelly, Manager, MSMS Department of Government Relations.

House bills

House Bill 4125-30—Liver Transplants
Sponsor: Representative Victor Krause (R-Rockford)
HB 4125 requires the state Medicaid program to pay for medically necessary liver transplants. HB 4126-4130, which are tie-barred, require insurance companies, Blue Cross and Blue Shield of Michigan, and HMOs to provide coverage for liver transplants. Introduced 2/14/85. HB 4126-29 referred to House Committee on Social Services and Youth. HB 4126-29 referred to House Insurance Committee. HB 4130 referred to House Committee on Public Health.

House Bill 4279—Chiropractic Scope of Practice
Sponsor: Representative Lloyd Weeks (D-Warren)
This bill would expand the scope of practice for chiropractic by permitting the use of physical therapy, x-rays for full skeletal system, and nutritional supplements. Introduced 2/28/85. Referred to the House Committee on Public Health.

House Bill 4477—Physician and Health Facility Licensing
Sponsor: Representative Burton Leland (D-Detroit)
This bill would require a 3-year loss of license for all health professionals and facilities upon criminal conviction of fraud. Introduced 3/25/85. Referred to the House Committee on Public Health.

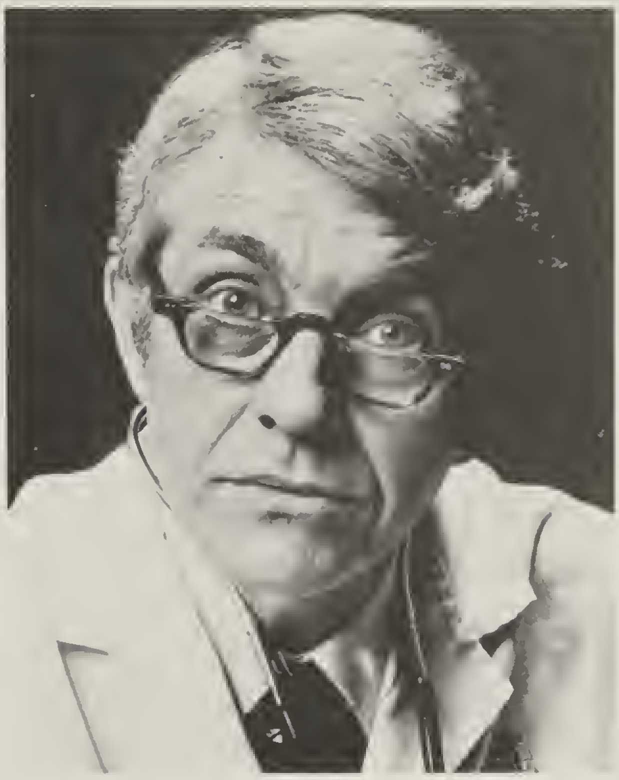
House Bill 4500—Smoking in Public Places
Sponsor: Representative Justine Barnes (D-Westland)
This bill provides for the regulation of smoking in public places and at meetings of public bodies. Introduced 3/27/85. Referred to House Committee on Public Health.

House Bill 4536—Patient Approval
Sponsor: Representative Wilbur Brotherton (R-Farmington)
This bill would require the approval of the patient before the administration of each test by a hospital. Introduced 4/3/85. Referred to the House Committee on Public Health.

House Bill 4549—Breast Cancer/Alternative Treatments
Sponsor: Representative Maxine Berman (D-Southfield)
This bill would require physicians treating patients with breast cancer to inform patients about alternative methods of treatment. Introduced 4/3/85. Referred to House Committee on Public Health.

House Bill 4625-28—Reimbursement for Nursing Services
Sponsor: Representative Debbie Stabenow (D-Lansing)
This bill would require the third-party reimbursement of nurses by medical care corps, hospital services, and health

Continued on page 56



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insurance companies. Introduced 4/30/85. Referred to the House Insurance Committee.

House Bill 4651-52—Respiratory Care
Sponsor: Representative Curtis Hertel (D-Detroit)
This bill provides for the licensing and fees for respiratory care practitioners. Introduced 5/21/85. Referred to the House Committee on Public Health. Re-referred to the House Committee on Appropriations on 6/25/85.

House Bill 4864—Itemized Lab Reports
Sponsor: Representative Curtis Hertel—(D-Detroit)
This bill would require health care professionals to furnish an itemized invoice to their patients for lab work. Introduced 6/20/85. Referred to House Committee on Public Health.

House Bill 4965—Anatomical Gifts
Sponsor: Representative Richard Bandstra (R-Grand Rapids)
This bill would require hospitals to request permission from family members to remove healthy organs from the deceased person. Introduced 9/18/85. Referred to the House Committee on Public Health.

House Bill 5048—Patent Medicines
Sponsor: Representative Ethel Terrell (D-Highland Park)
This bill would include patent medicines under Medicaid coverage. Introduced 10/2/85. Referred to the House Social Services and Youth Committee.

Senate bills

Senate Bill 56—Clinical Labs Overutilization
Sponsor: Senator Alan Cropsey (R-DeWitt)
The bill permits licensing boards to impose sanctions on health care providers for overutilization and requires physicians and clinical labs to report financial interest in labs. Introduced 2/5/85. Referred to Senate Committee on Public and Mental Health.

Senate Bill 71—Clinical Laboratories
Sponsor: Senator William Sederburg (R-E. Lansing)
This bill prohibits physician referral of patients to clinical laboratories in which the physician has a financial interest. Introduced 2/12/85. Referred to Senate Committee on Public and Mental Health.

Senate Bill 259—Chiropractic Services/HMOs
Sponsor: Senator Kirby Holmes (R-Utica)
This bill would include chiropractic services within the services provided by health maintenance organizations. Introduced 4/30/85. Referred to Senate Committee on Public and Mental Health.

Senate Bill 330—Medicaid Privitization
Sponsor: Senator Robert Geake (R-Northville)
This bill would allow private firms to contract for the administration and underwriting of the State's Medicaid program for at least four years. Introduced 5/22/85. Passed Senate 6/11/85. Referred to the House Committee on Appropriations.

Senate Bill 391—Physical Therapists
Sponsor: Senator Robert Geake (R-Northville)
This bill would provide certain education requirements for physical therapists and expand the definition of practice of physical therapists and expand the definition of practice of physical therapy. Introduced 6/19/85. Referred to Senate Committee on Public and Mental Health.

Senate Bill 428—Psychiatrists
Sponsor: Senator William Sederburg (R-E. Lansing)
This bill would amend the definition of psychiatrist under the Mental Health Code to require a person to have practiced psychiatry for one continuous year in the three years preceding certification. Introduced 9/19/85. Passed 10/23/85. Sent to House Mental Health Committee.

Senate Bill 436—Health-Hospital Finance Authority
Sponsor: Senator Richard Fessler (R-W. Bloomfield)
This bill would create a state hospital finance authority to provide for the financing of alterations and/or improvements of health care facilities. Introduced 9/19/85. Referred to the Senate Finance Committee.

Senate Bill 460—Health Insurance
Sponsor: Senator Jack Faxon (D-Southfield)
This bill would require consumer notification of duplicate coverage of Medicaid supplemental policies. Introduced 10/11/85. Referred to the Senate Commerce Committee.

Senate Bill 579—Vaccines
Sponsor: Senator William Sederburg (R-E. Lansing)
This bill would revise the enabling statute for the production of vaccines by state laboratories and allows for the development and production of pharmaceutical, biologic, and diagnostic products and by-products for distribution or sale outside the state if the distribution or sale will not impair any program in the state. Introduced 11/19/85. Referred to the Senate Public and Mental Health Committee.

Senate Bill 580—Immunity for Biologic Products
Sponsor: Senator William Sederburg (R-E. Lansing)
This bill provides for the immunity from liability for production of certain pharmaceutical, biologic, and diagnostic products by state-owned laboratories. Introduced 11/19/85. Referred to the Senate Public and Mental Health Committee.☐

By Carole Eberly

Scientist—turned—legislator urges MDs to return to civic duties

Senator Vern Ehlers, PhD, Phi Beta Kappa, Chairman, Senate Committee on Public and Mental Health and author of such scientific papers as "Nuclear Spin, Hyperfine-Structure Separation and Magnetic Moment of 22-hour Potassium-43," is the first to admit it:

"I'm either unique or strange, depending on your point of view," he said of his careers in physics teaching and research at Calvin College and his tenure in the state legislature.

Ehlers maintains his scientific background helps in dealing with legislative issues.

"But it's difficult to persuade scientists to think about political office," he said. "There's usually just not much interest there."

One issue Ehlers is looking at this year is the whole area of organ transplantation. Bills being readied include one to require hospital personnel to ask survivors of brain-dead patients to donate organs. Another would have Secretary of State workers ask persons to consider organ donation at driver license renewal time.

A special Senate committee studying the organ transplant situation in Michigan is looking at designating certain hospitals as transplantation centers and others as harvesting centers.

"The way it is now, you need two kinds of transplantation teams," said Ehlers. "One waits at the hospital for the organs while the other goes out and harvests the organs. It doesn't appear to be the most economical or efficient way to go."

Here I am

Ehlers, 52, ran for the Senate in 1985 as a Republican in a special election created by the move to Congress of former

---

Ms. Eberly is a Lansing-area freelance writer.

Continued on next page

EHLERS/Continued

Grand Rapids Senator Paul Henry. Ehlers, who had served in the House since 1982, said he never intended to wind up in the legislature. He simply worked in various civic and community organizations, as well as on some political campaigns. From 1975-83 Ehlers served on the Kent County Board of Commissioners.

"One thing led to another, and here I am," he said.

Ehlers, who strongly believes that responsible citizens work in civic, church and community affairs, had a few harsh words for physicians in that area.

"Doctors used to be the pillars of their communities," he said. "They no longer are. The question is, why aren't they? What has changed? What has happened? I think the medical community should be addressing that—and very promptly, very directly."

He said many rural physicians still maintain strong community ties.

"But in metropolitan areas, you don't see that," he said. "They're not active in politics, they're not active in civic affairs. Some are active in churches, but it's not the same as it used to be. The medical community has to try to restore that."

Ehlers saw the community tie breakdown as just one of many causes of the current medical malpractice situation.

He labeled medical malpractice as "an extremely complex issue," and had much criticism for the insurance industry.

"First of all, the insurance companies have not administered their affairs very well," he said. "They almost deliberately lost money for several years to get more capital that they could invest in high interest rates. The interest rates dropped precipitously and they were caught holding the bag. They lost a lot of money. So, they had a great need to raise their rates."

Ehlers also blamed the malpractice mess on the "litigious mentality" of society.

"If anything goes wrong, you don't assume you are partially responsible," he said. "You assume that everyone else is. So, you sue everyone in sight."

He also pointed a finger at the medical community for not always informing patients of the risks involved in certain procedures, making it clear that things could go wrong.

Doctors are not active in politics, they're not active in civic affairs . . . The medical community has to try to restore that.

"There's a real failure in society to distinguish between the poor practice of medicine and poor results of medical procedures," he said. "And poor results are often not the fault of the doctor."

Ehlers said the public has to be taught the difference between poor outcome and poor practice.

Committee work

Since Ehlers is part of the GOP majority in the Senate, he is expected to take on the responsibilities of chairing a committee—in his case the Public and Mental Health Committee.

While juggling all the legislation that come before that committee, he is also expected to be knowledgeable on other issues before the legislature. This is where he finds associations, such as MSMS, invaluable.

"If I have a question on a (medical) issue, I will call Manager of MSMS Government Relations Kevin Kelly and ask how the medical society views the issue," he said. "It is very important to me to have that information. Now that puts a tremendous burden on him because that means he has to maintain good contact with members of the medical profession so he is giving me the right answers.

"But I think the whole process is essential. And I do the same thing with osteopaths, dentists and other groups. They provide a channel between individual practitioners and individual legislators."

But while Ehlers maintains a hectic schedule keeping on top of legislation, he puts his home life first.

He and his wife Johanna have four children, although only one still is living at home. He makes the 70-mile Grand Rapids-Lansing drive as often as possible.

"When legislators come here Monday and don't go home until Thursday, it raises havoc with their family life," he said.

He said that is the reason there are so few mid-aged legislators.

"They're mostly younger or older, before or after they've raised a family," he said.

Does Ehlers, who looks every bit the physics professor he was, yearn for the days of academia?

"I might go back someday," he said. "I miss the academic atmosphere. I miss the pleasant intellectual discourse. You don't deal that much with abstract ideas here. Today's problem has to be solved today—tomorrow at the latest. It's a different life."☐

MSMS hosts reception for Board of Medicine

aymond Hood, Director, Michigan Department of Licensing and egulation chats with Carl A. Gagliardi, MD, chairman, MSMS Board of irectors, during a November 20 reception at MSMS headquarters. The vent was held to honor the members of the Michigan Board of edicine.

Julie Knoll, Licensing and Regulation staff member, Bill Howe, chief of the L & R Health Services Bureau talk with James Fenton, MD, right, former chairman of the Michigan Board of Medicine.

Doctor Fenton is pictured with Board of Medicine members Robert Gibson, MD, center, and Larry Andreini, MD, right.

Charles C. Vincent, MD, new Board of Medicine chairman, is congratulated by MSMS President-elect Thomas R. Berglund, MD, right.

DEATHS

Arthur W. Fleming, MD
Des Plaines, IL
Doctor Fleming died September 2. He graduated from the Rush Medical School in 1933. Doctor Fleming was a board certified pediatrician and had been affiliated with University Hospital in Ann Arbor.

Johnson

Orlen J. Johnson, MD
Bay City
Doctor Johnson, former MSMS president, died December 6 at the age of 80. Doctor Johnson graduated in 1931 from the University of Michigan Medical School and served as chief of staff at General Hospital and Mercy Hospital. He had been chief of emergency room services at Bay Medical Center, and former president of the Bay, Arenac, and Iosco Counties Medical Society.

Alvin G. Lambert, MD
Stuart, FL
Doctor Lambert died September 16 at the age of 83. Doctor Lambert practiced for 40 years in Royal Oak and had been on the surgical staff at William Beaumont and Crittenton hospitals. He had been chief of surgery at Ford Industrial Hospital in Para, Brazil.

Ernest B. Miller, MD
Largo, FL
Doctor Miller died October 18 at the age of 80. He graduated from Rush Medical College, University of Chicago in 1934. Doctor Miller had been affiliated with Mercy Community Hospital, Manistee.

Waldo A. Schaefer, MD
Port Huron
Doctor Schaefer died April 28 at the age of 90. An ear, nose, and throat specialist, he maintained an active Port Huron practice from 1928 until 1984.

William V. Taylor, MD
Detroit
Doctor Taylor died November 3 at the age of 66. He received his medical degree from the University of Tennessee. Doctor Taylor practiced in his East Detroit office for 33 years and served on the staffs of Cottage, Saratoga and Deaconness hospitals.

W. Paul Ward, MD
Birmingham
Doctor Ward died November 26 at the age of 70. He graduated from Rush Medical School, University of Chicago in 1941. he was affiliated with William Beaumont Hospital in Royal Oak and retired in 1983.

Martin K. Wyngaarden, MD
Grand Rapids
Doctor Wyngaarden died November 21 at the age of 58. He graduated from the University of Michigan Medical School in 1953, and practiced pediatrics and cardiology for 30 years in Grand Rapids. Doctor Wyngaarden was on staff at Butterworth Hospital and Blodgett Medical Center.

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R. Tyler, M.D.
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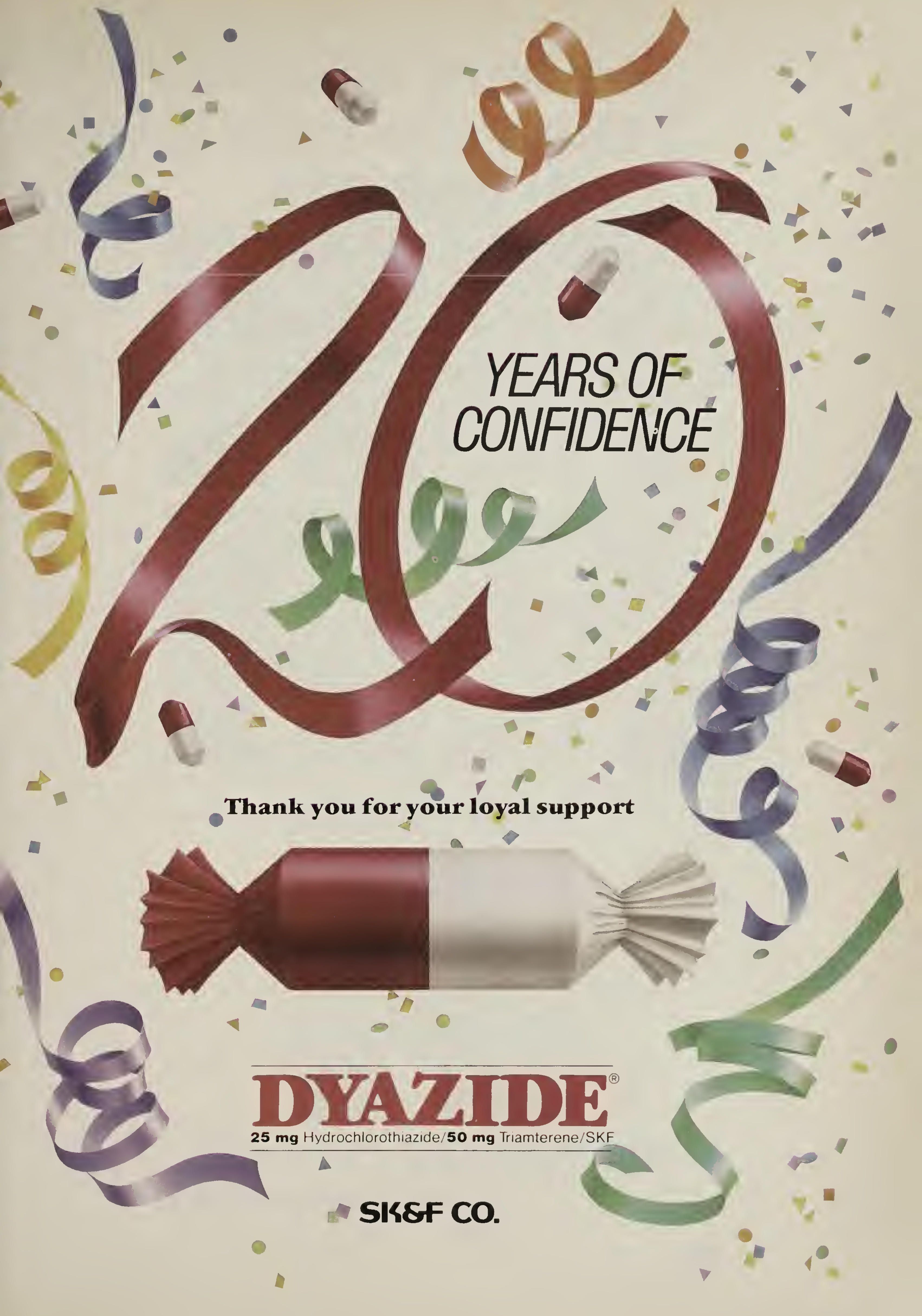
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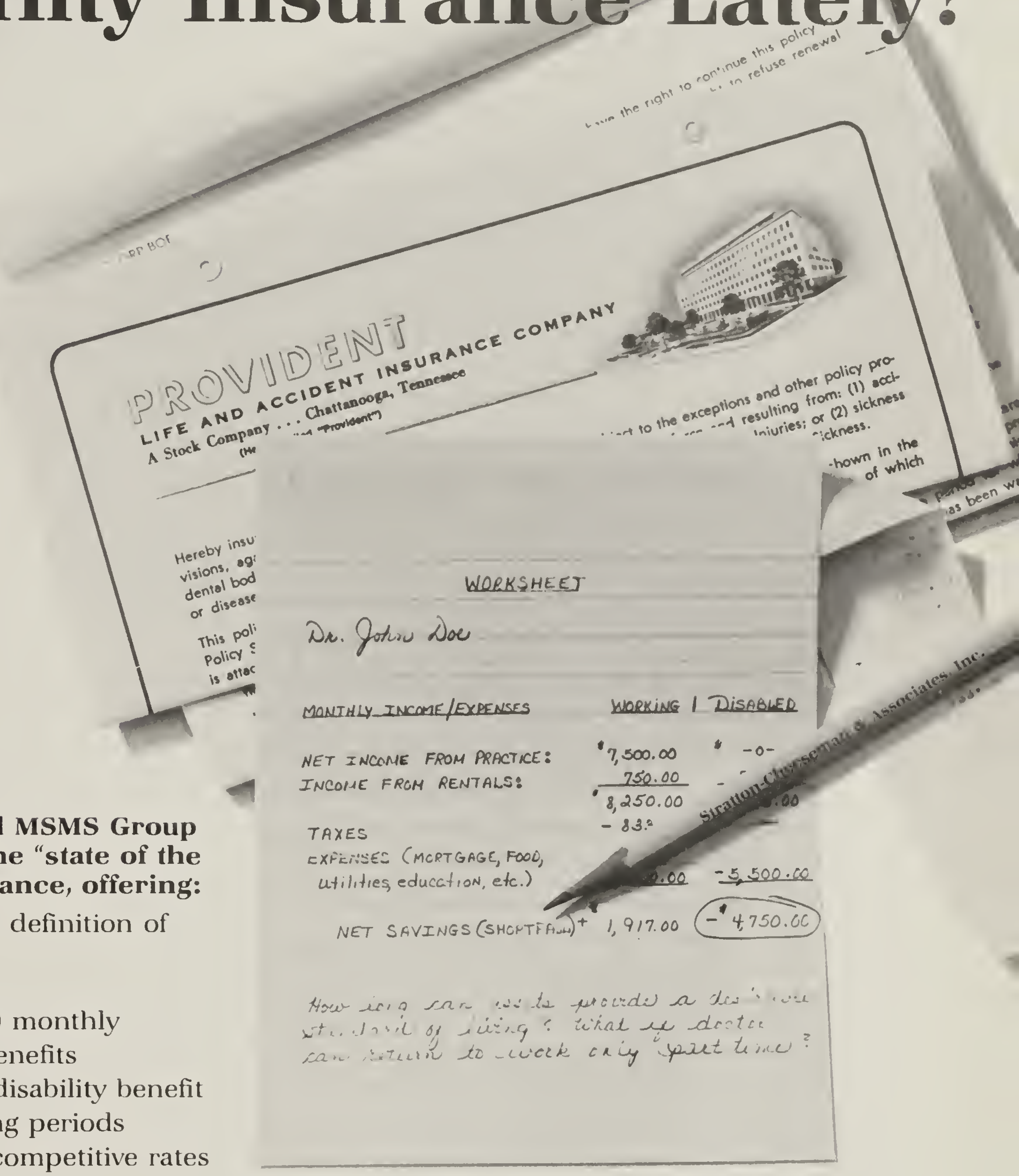
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By Harold E. B. Humphrey, PhD and Lawrence Chadzynski, MPH

Michigan focuses on human exposure to environmental contaminants

Authors Humphrey and Chadzynski are MDPH Scientific Liaison Coordinator and Director, MDPH Center for Environmental Health Sciences, respectively.

Environmental quality has become synonymous with quality of life in Michigan over the past twenty years. Whether real or perceived, exposure to toxic contaminants has captivated the interest of both environmentalists and citizens of our state. Evidence of synthetic organic contaminants in our air, water, soil or food has raised profound questions about the possible acute or chronic human health consequences of these exposures. In too many cases there is a paucity of knowledge and no textbook answers to these questions.

The Michigan Department of Public Health has the responsibility to prevent disease and advise the public about avoidable risk. The Center for Environmental Health Sciences (CEHS) focuses efforts to generate, interpret and communicate information on the issues associated with environmental health hazards. With no simple answers at hand, the task of properly advising the public has required and relies on the implementation of far-reaching and innovative investigations which are receiving professional recognition worldwide. The following are capsule accounts of several of these initiatives.

Contamination of the food supply in 1973 with polybrominated biphenyl (PBB) not only raised questions about the meaning of exposure to humans but also created a unique opportunity to study a human population which had received a singular exposure to a chemical which could be quantitated at the onset. The design and initiation of a pro-

Continued on page 66

By E. Joseph Alberding, MD

MDPH Liaison Committee launches new series here

The MSMS Liaison Committee with the Michigan Department of Public Health was established to "improve information and communication channels among public health officers, practicing physicians, and the public on environmental and public health issues of mutual concern." The committee meets with representatives of the Department of Public Health about four times each year to discuss public health issues of current concern to both MSMS and the department.

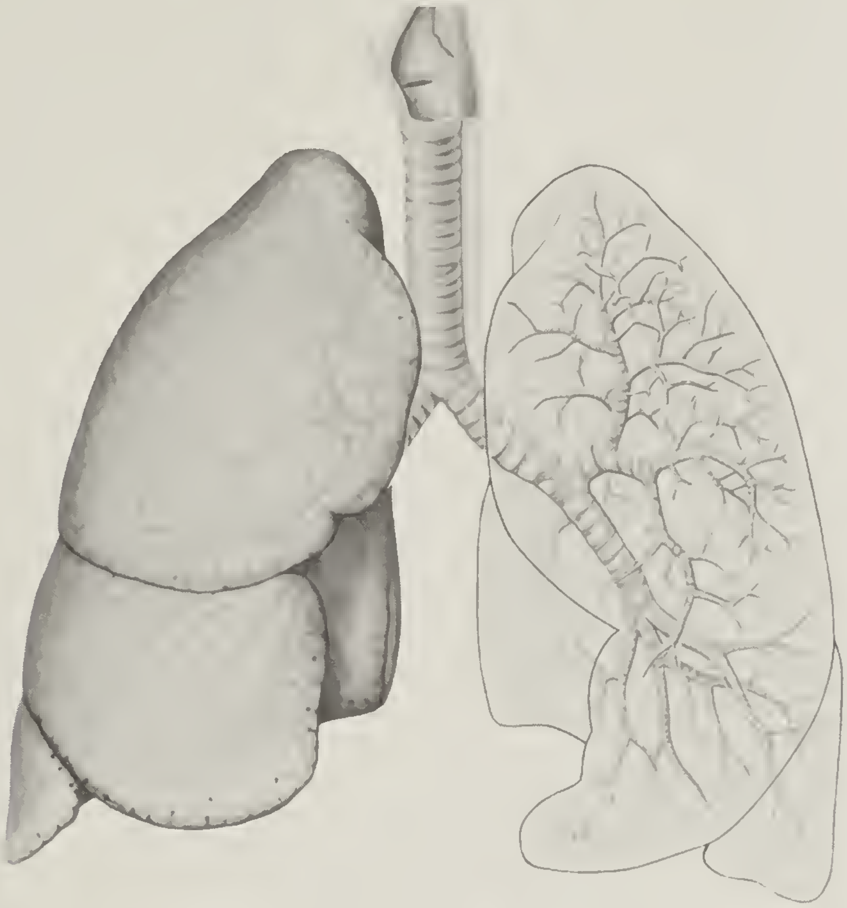
Our most recent meetings have included discussions of the reorganization at MDPH, which emphasize the department's efforts to promote healthier lifestyles in Michigan, and to better coordinate state and local public health programs. As the public health needs of Michigan change, MDPH has engaged in ongoing efforts to meet those needs. The department relies on the MSMS Liaison Committee to provide information on physician needs, and on physicians' expectations from the department.

In an effort to better inform MSMS members of the services available to physicians through MDPH, and of the public health issues which the department considers to be priorities, the committee inaugurated a series of articles on MDPH in this issue of *Michigan Medicine*.

This month's feature is an update on the Center for Environmental Health Services. Future issues of *Michigan Medicine* will feature articles on each of the six major divisions of the Michigan Department of Public Health. The Liaison Committee with MDPH is enthused about this opportunity to keep MSMS members up to date, and welcomes readers' comments on this series.☐

Doctor Alberding, Kalamazoo, is chairman, MSMS Liaison Committee with the Michigan Department of Public Health.

Consider the causative organisms…



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Contraindication Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

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Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile* Other causes of colitis should be ruled out

Precautions *General Precautions* – If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued and, if necessary the patient should be treated with appropriate agents e g pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease particularly colitis

Usage in Pregnancy – Pregnancy Category B – Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor® (cefaclor, Lilly) There are however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers – Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0 18 0 20, 0 21 and 0 16 mcg/ml at two three, four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children – Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain – Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic – Slight elevations in SGOT, SGPT or alkaline phosphatase values (1 in 40)

Hematopoietic – Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal – Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[D617B2R]

Note Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

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spective epidemiological cohort study of significantly exposed persons has allowed the Center to monitor body burdens and health events for a decade. Enrollment covered the entire lower peninsula and 93.6% of the 4,980 persons contacted agreed to participate in the study. The enrollment categories and PBB concentrations found in those who provided serum specimens are illustrated in Table 1.

Remarkably, attrition from this cohort has been low, preserving the statistical integrity of health outcome data recorded as the study continues past the latency period for this exposure. Although the question of the appearance of delayed illness remains to be answered, the study has generated a number of findings important to understanding the impact of an exposure event such as PBB. These include: (1) the occurrence of subjective symptoms known as the "PBB syndrome," although frequently reported at the onset, have subsided today; (2) neither subjective symptoms nor the occurrence of definable disease have correlated with PBB serum levels; (3) PBB continues to be retained in the body and serum concentrations have shown only slight declines; (4) PBB crosses the placenta; (5) fertility and neonatal health do not appear to have been affected; (6) compared to serum concentrations, PBB in breast milk and body fat are approximately 100 and 250 times greater respectively; (7) PBB is found in most tissues of the body; and (8) comparison of the mortality and morbidity rates for this cohort are, at this time, within the ranges expected from state and national statistics. Continued surveillance of this cohort will provide valuable information on the long-term outcome of exposure to this persistent toxic compound.

TABLE 1

Serum Concentrations* for Enrollees in the Michigan Long Term PBB Study

Residents of	No. Persons	Range (ppb)	Median (ppb)
Quarantined Farms	1842	<1-1753	4
Recipient Farms	1272	<1-1194	3
Low Level PBB Farms	293	<1- 24	2
Chemical Co. Workers	354	<1-3150	3

*parts per billion

TABLE 2

PCB and DDT Serum Concentrations* Found in Michigan Citizens

Fisheaters >24 lbs/yr.			Comparison >6 lbs/yr.		
Contaminant	Range	Median	Contaminant	Range	Median
PCB	<3-203	21.4	PCB	<3-60	6.6
DDT	<1-512	26.4	DDT	<1-90	10.5

*in parts per billion

Aquatic contaminants

Consumption of sport caught fish represents a significant source of exposure to aquatic contaminants, especially those which are also persistent, such as PCB and DDT. In an effort to better define the risk of exposure, the Center recently enrolled a cohort of 572 fisheaters and 419 comparison persons from 10 shoreline communities along Lake Michigan. This represents the largest study of Great Lake fishermen ever assembled. Evaluation of serum specimens showed a clear association between fish consumption and contaminant exposure in humans. The levels of PCB and DDT found in the two groups illustrates this in Table 2.

Human exposure correlated with the quantity of sport caught fish eaten, the number of years fish had been consumed, the species of fish regularly eaten, the preparation and cooking techniques used and to a slight extent, the geographic area from which the fish were obtained. The investigation has established a study group who, because of personal preferences, are intermittently exposed to aquatic contaminants. Continued surveillance of these participants will allow assessment of exposure to additional contaminants as they are reported

Continued on page 68

Transportation:
Delivery of patient specimens is the first step in providing laboratory testing services. The Advance Medical & Research Center, Inc. transportation department provides specimen pick-up and twenty-four-hour turnaround time of test results by employing more than 60 couriers, daily air flights and report transmission by high-speed teleprinters.

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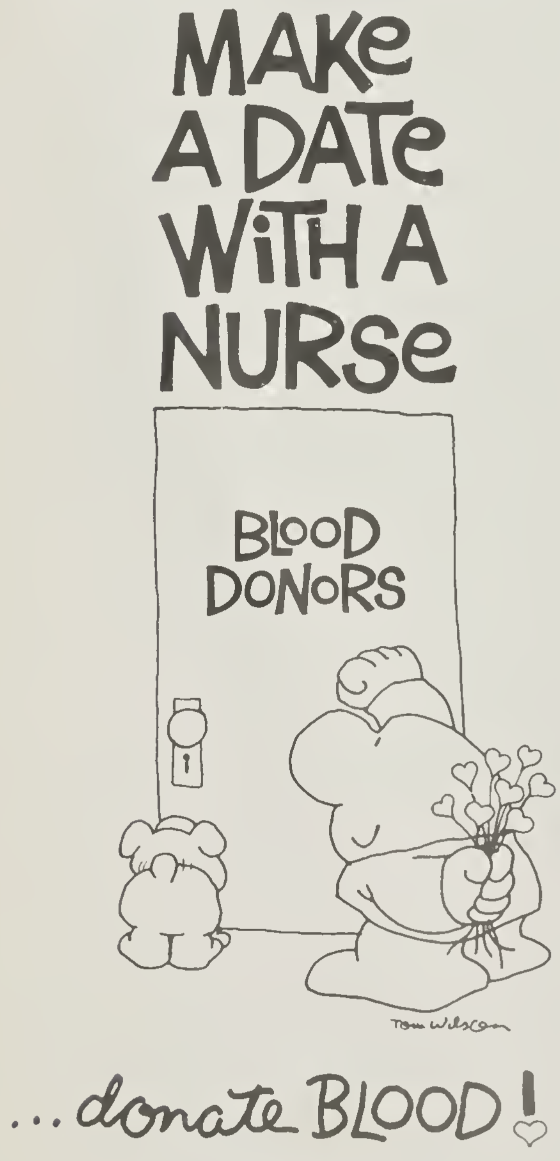
CONTAMINANTS/Continued

and the health outcome of this type of exposure over time. Michigan has a close association with the Great Lakes. Identification of the impact of this resource on humans represents one of the goals of the Center for Environmental Health Sciences.

Research projects

Major investigations such as those described above provide the opportunity to establish multi-disciplinary collaborative research projects which can introduce state-of-the-art techniques to measure biological damage or adverse health impacts. Currently, investigators from several universities are working with the Center on the following projects: comparative evaluation of a 1,500 person cohort from the state of Iowa; comparative multivariate statistical evaluation of the established data bases; evaluation of biological damage to the liver by measurement of mixed function oxydase enzyme activity; evaluation of the endocrine system as a function of change in the normal sexual maturation of children; evaluation of fetal exposure in terms of behavioral development and learning ability in four-year-old children: evaluation of metabolic function by measurement of urinary steroid hormone metabolite profiles; and evaluation of immune system impact in terms of cell populations and function. Each of these projects will add to the scientific/medical knowledge base and assist the Center in its efforts to identify and prevent adverse human health impacts from exposure to environmental contaminants.



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In addition to maintaining established projects, the Center proposes to begin a number of new initiatives intended to identify problems, impacts and remedies and to aggressively disseminate information and advice about environmental health problems to both the lay and professional publics. For example, the Center is supporting a local county health department in a demonstration project which will develop an electronic methodology and capability for establishing a working inventory of toxic chemical manufacture, use, storage, transport and disposal practices. Once developed, this system would be made available to other local health departments. The Center is in the process of establishing a telephone "hotline" for two way communication with the public on toxic exposure matters. In order to improve the efficiency and speed of response to these events the Center intends to work more closely with and strengthen the role of local health departments in this area. The Center has begun a major investigation of the impact of human exposure to volatile organic chemical contamination in drinking water in the Battle Creek area and has initiated a study of the diagnosis and incidence of soft and connective tissue sarcoma in nine counties including Midland County.

Additional projects which are being planned include evaluation of health effects associated with urea formaldehyde foam and other pollutants in the home environment; support of research to study ways to reduce toxic chemical body burdens; development of a system for disease surveillance and cancer cluster analysis related to geographical exposure sites, and evaluation of the multi-generational impact of human exposure to persistent fat soluble chemicals.

The PBB incident demonstrated that practicing physicians needed a link to the fast-paced developments during the heat of an event. The CEHS intends to develop an environmental health network which will promote greater understanding of the health implications of environmental pollutants by providing timely information and thorough analyses to medical professionals and allied health personnel. This will be accomplished through organization of a communications network among the associations, schools and agencies concerned with public health and the delivery of health care. The goal of the Center and this network will be to place us in a proactive rather than in a reactive role in dealing with the public and its concerns as they relate to toxic chemical substances.☐

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Board of Medicine actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

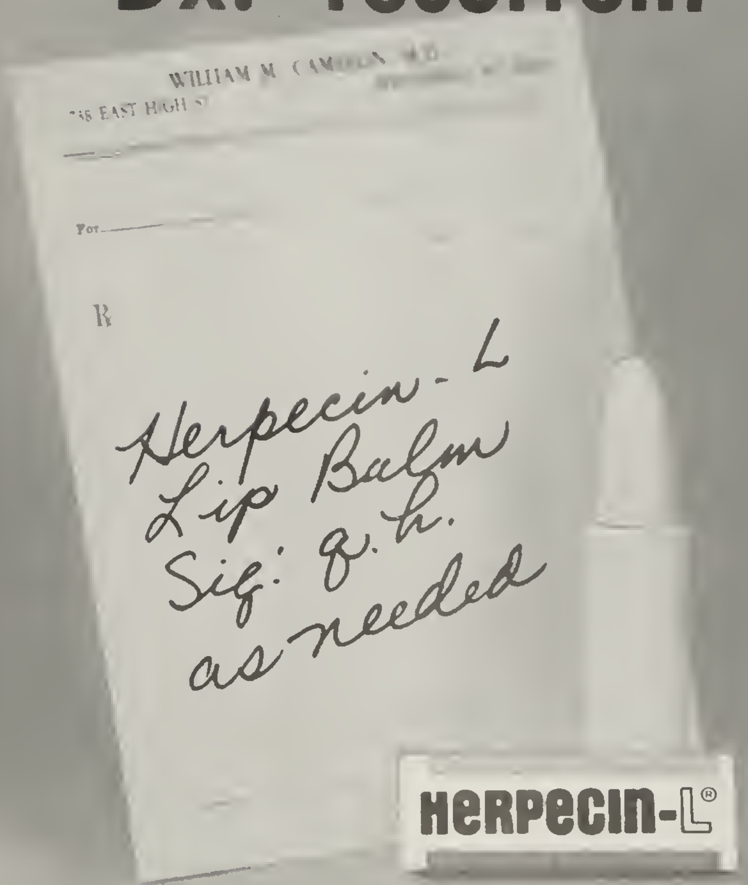
Name: Norbert O. Anderson, MD **Action, Date Taken:** Suspended two (2) years—12/15/85. **Reason:** Board of Medicine order dated 11/13/80 upheld by State Court of Appeals.

Name: Gertrude C. Black, MD **Action, Date Taken:** Limited license until 2/18/86 whereupon she shall permanently surrender her license to practice medicine. **Reason:** Departed or failed to conform to minimal standards of acceptable and prevailing medical practice. Prescribed drugs for other than lawful diagnostic or therapeutic purposes.

Name: Jack W. Marrs, MD **Action, Date Taken:** Suspended one (1) year (3 weeks served, 49 remaining from 10/28/85.) **Reason:** Michigan Supreme Court reinstated Board of Medicine order.

Name: Jarold C. Patterson, MD **Action, Date Taken:** Limited license 11/6/85. **Reason:** Departed or failed to conform to minimal standards of acceptable and prevailing medical standards.

Name: Carl Sloth, MD **Action, Date Taken:** Suspended six (6) months and one (1) day—10/16/85. **Reason:** Mental or physical inability reasonably related to and adversely affecting his ability to practice medicine in a safe and competent manner. ☐



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Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: **Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of Dyrenium (triamterene, SK&F CO.) and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (Intended for Institutional use only); In Patient-Pak™ unit-of-use bottles of 100.
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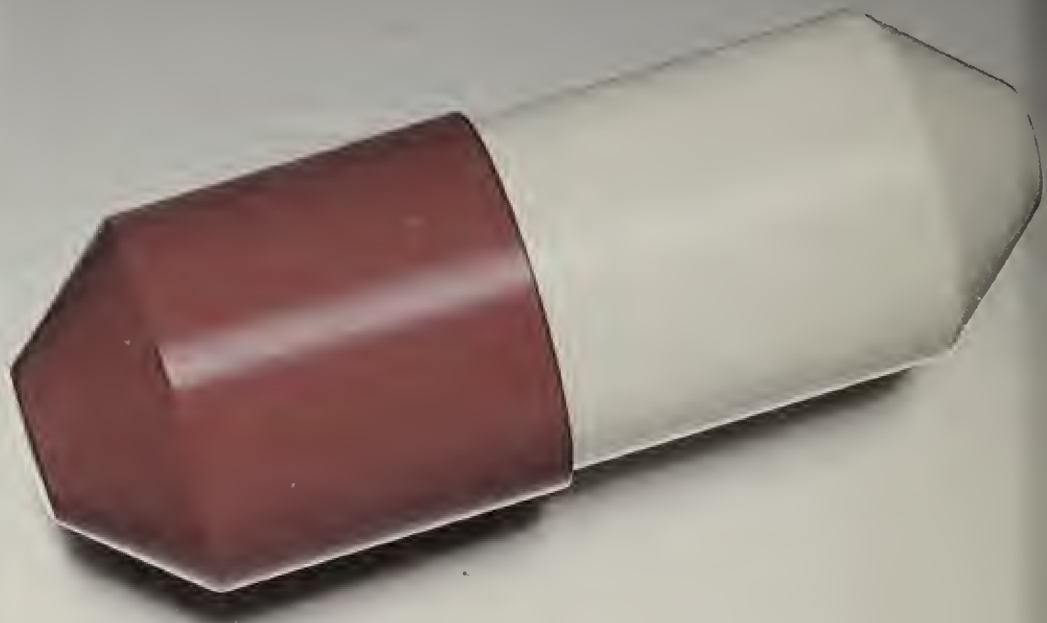

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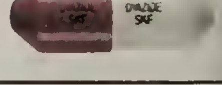

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Annual Scientific Meeting photo highlights

C. Edward Cotton, MD, 1985 Annual Scientific Meeting Chairman, center, is flanked by Samuel M. McMahon, MD, Lansing, left, and Rudi Ansbacher, MD, Ann Arbor, right. Doctors McMahon and Ansbacher are 1986 co-chairmen of the Planning Committee for the MSMS Annual Scientific Meeting. The three doctors are pictured greeting some of the more than 1,100 physicians who attended the November 12-14 meeting at the Hyatt Regency Dearborn.

Richard J. McMurray, MD, MSMS president, looks on from the back row as another physician asks a question of one of 45 course speakers.

Joan C. Stryker, MD, Detroit, discusses one of the many clinical poster exhibits with Doctor Ansbacher. The posters were displayed during *two* days of the meeting, after a successful one-day exhibit debut in 1984.

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Services to help physicians reduce the chances of liability claims are among the benefits that MPMLC provides policyholders. MPMLC is offering its Malpractice Awareness Program (MAP) workshops for the second year to assist physicians identify risks and ways to avoid them. The company's MAP sessions provide doctors vital information based on confidential analyses of closed claims. Loss prevention is gaining recognition as an effective strategy to reduce the costs of medical liability insurance.

Watch for new MPMLC programs to assist policyholders minimize risks in the practice of medicine.

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MSMS Legislative Network at work

David Harold, MD, Pontiac, far right, paid a visit to State Senator Doug Cruce (R-Troy), center, as part of the Physician Legislative Network last December. During the day-long visit Senator Cruce told Doctor Harold he "could not have chosen a more opportune time" to visit the Capitol as liability issues now are "priority agenda items." Doctor Harold's son, Danny, participated throughout the day. For details on the Physician Legislative Network, contact Daniel Farhat at MSMS headquarters.

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National study of health outcomes of treatment for chronically ill

What features of the medical care system produce good health outcomes for patients with chronic disease? How much does it cost to maintain the well-being of people with serious medical problems like heart disease, depression, diabetes and hypertension? What effects are cost-saving measures likely to have on people's health?

The Rand Corporation will seek answers to those and other questions in a comprehensive study of how the nation's medical care system affects chronically ill patients. The study was launched in Los Angeles, the first of six study sites being selected in various locations around the country.

Funded by the Robert Wood Johnson Foundation of Princeton, NJ, and the Henry J. Kaiser Family Foundation of Menlo Park, the $8.5 million National Study of Medical Care Outcomes will also explore how patients fare in different kinds of health care settings.

"Competition among different provider specialty groups and different health care systems is increasing as each tries to contain rising health care costs," said research psychologist John Ware, director of the project. "The debate over which system is best is now being decided in terms of which can save the most money without considering which is best in terms of patients' health. This study has been designed to focus attention on the health outcomes of treatment and on patient satisfaction with care."

Researchers will evaluate how outcomes of treatment are influenced by two important factors: the different specialties of medical practitioners and the types of health care systems in which they practice.

Three kinds of organizations will be studied: the prepaid group practice form of health maintenance organization, which charges the same premium regardless of how much treatment the patient gets; the large, multispecialty group practice, where a fee is charged for each service; and physicians who practice alone or in a small group and charge on a fee-for-service basis.

A major feature of the study is its emphasis on the patient's point of view. Thus, in addition to the results of tests such as blood pressure that doctors traditionally use to keep track of how well patients are doing, the study will use questionnaires to measure how well patients function physically and mentally in everyday life and how satisfied they are with the care they recieve.

Ware said people with chronic diseases were chosen for study because they account for the great majority of health care expenditures and they have the most to gain or lose from recent and proposed changes in the medical care system.

"The overall aim of the study," he said, "is to identify those features of the medical care system that are essential to good health outcomes so they can be preserved as the nation's health care delivery system is restructured in the drive to control costs."

Rand's first step in carrying out the study will be to enlist the participation of about 750 physicians, including family practitioners, general internists, cardiologists, endocrinologists and psychiatrists. The physicians will be evenly divided among the study sites. Some clinical psychologists also will be enrolled.

About 80,000 patients, 18 years and older, will be screened for possible enrollment in the study. From that group, about 4,800 patients with one of four chronic diseases—diabetes, high bloo pressure, heart disease and depression—will be enrolled for two years, and their contacts with the health care system will be monitored during that time.

The researchers will gather data from patients, their physicians and other health care providers using questionnaires mailed in at regular intervals. Other methods of gathering data also will be used, including telephone interviews, medical care visit forms completed by both physicians and patients, and patient health diaries.

Ware emphasized that the procedures have been extensively tested in a pilot program and that all information gathered during the study will be held confidential and aggregated to protect the identity of the physicians and patients who participate.

The study has been endorsed by the American Academy of Family Physicians, the American College of Physicians and the American Psychiatric Association. Representatives o these organizations along with practicing physicians in the medical specialties that are being studied serve on a committee that advises the researchers.

The Rand Corporation is an independent, nonprofit institution engaged in research and analysis of problems affecting the nation's security and domestic welfare. It also conducts educational activities, including a doctoral degree program in policy analysis. Rand is headed by Donald B. Rice, president. The medical outcomes study is being carried out in the domestic research division, which is under the direction of David W. Lyon, vice president.

anic attacks studied

Vhile waiting in line at a tore, a 24-year old woman vas seized with panic. Her eart beat quickly, her reathing was rapid and her alms perspired. She said she elt as if she were about to ie. It was, she later said, "like eing hit with a ton of bricks."

Nevertheless, by the time she rrived at an emergency room he was feeling almost normal nd the doctor could find no hysical abnormality to acount for her experience.

U-M Medical Center doctors iagnosed this person as suffering from a panic attack, a udden dramatic attack of anxety followed by a period of ormal behavior. One to two ercent of the population, as nany as four million people, re estimated to suffer from anic attacks. Twice that umber suffer some type of nxiety disorder.

Anxiety problems range from ears or phobias about specific ituations, like heights or rowds, to chronic anxieties bout several interrelated problems such as health ifficulties.

In some cases, says George C. Curtis, MD, the U-M sychiatrist who directs the Hospital's Anxiety Disorders rogram. Individuals will begin avoiding certain activities or places for fear of experiencing uther panic attacks, ultimately becoming a prisoner in their own home afraid to venture into the outside world.

Doctor Curtis and his colleagues have been studying the causes and cures of anxiety disorders and are looking for volunteers to help in this research. In order to participate, persons should not currently be taking daily medications for "nerves," anxiety or depression.

The project will test the effectiveness of newly developed medications that appear promising for the treatment of panic attacks.

Participants accepted into the study will receive physical, laboratory and psychiatric examinations at the beginning and at regular intervals during the project. There will be no cost to participants for any of the services that are part of the study.

For further information, contact the Anxiety Disorders Program, University Hospital, Ann Arbor 48109 (313)764-5348.

Wayne State makes DNA chains

The newest equipment addition to the chemistry department at Wayne State University looks like little more than a personal computer with a large medicine cabinet at its side.

Yet, this computer/machine combination is perking up the ears of campus scientists. While most other chemistry equipment is performing the usual analysis work, this new machine is busy making genetic material—DNA.

"This represents a new direction for us," said Robin J. Hood, MD, director of the WSU Central Instrumentation Facility. "This is perhaps the beginning of the Center for Molecular Synthesis."

The department bought the $35,000 DNA synthesizer with money from the provost instrumentation fund, the Michigan Cancer Foundation and the National Institute of Health. Doctor Hood took a course in California to learn how to operate it, and since its installation, has been pumping out DNA chains to order.

"It's very easy to operate," he explained. With a touch of a light stick on the computer screen, he enters the order in which he wants the four bases—the building block of DNA—to appear on the DNA chains. During the ensuing chemical reactions, the machine generates several milligrams of DNA, or 10^{18} individual DNA strands.

Once the base sequence is entered, the DNA synthesizer immobilizes the first base on a glass bead, performs the necessary chemistry to add on the second base, and so on.

"Manual kits have been available for a couple of years, but you couldn't add more than three or four bases a day," Hood said. "This machine adds one about every 10 minutes, so overnight it can make a chain of 50 to 60 bases."

The newly-created DNA strands can be used in cancer genetics and enzyme research and in many other areas.

Thoracentesis called safe and useful by ACP

Diagnostic thoracentesis is safe, well-tolerated by patients and can be done on an outpatient basis, according to a recent evaluation of the procedure by the American College of Physicians. The recommendation on thoracentesis, a procedure whereby fluid is removed from the chest cavity for diagnostic purposes, was prepared by the College's Clinical Efficacy Assessment Project (CEAP).

By obtaining a specimen using thoracentesis and performing selected laboratory tests on the fluid, a physician can accurately determine why a pleural effusion has developed. In some cases, the fluid may indicate the presence of a life-threatening disease. A timely, accurate diagnosis can lead to proper treatment.

The recommendation also states that since thoracentesis and pleural biopsy do not require complex equipment or hospitalization, the cost of the procedure is relatively low.

Complete copies of this and other CEAP recommendations may be obtained from the

Continued on next page

ACP. Contact: ACP Communications Division, 200 Pine Street, Philadelphia, PA 19104.

Reye's syndrome annual summary

From October 1, 1984 to September 30, 1985, 13 cases of Reye's Syndrome were reported to the Michigan Department of Public Health. The age of these cases ranged from two months to 16 years. The median age was 2.5 years and the mean age was 5.5 years. There were seven female and six male cases. Three cases died.

Based upon review of the cases' medical records, ten of the 13 reported cases satisfied the Centers for Disease Control case definition of Reye's Syndrome. One reported case had a final diagnosis of acetyl coenzyme A deficiency and the other two cases were excluded because there was no evidence of fatty metamorphosis of the liver by autopsy and/or elevated liver enzymes (3 x's uln).

Analysis of the data from the case-control study of the past three years is in progress. Although we will no longer seek study subjects, we encourage Reye's Syndrome Reporting Coordinators to continue reporting suspect cases by phone per the current system.

Diabetes research grants available

The Juvenile Diabetes Foundation announces the availability of grants in diabetes research for the funding year September 1, 1986 to August 30, 1987 (renewable for a second year).

Applications may be obtained from Grant Administrator, Juvenile Diabetes Foundation, 60 Madison Avenue, New York, NY 10010, 212-889-7575.

Each application is subject to scientific peer review by the Medical Science Advisory Board and approval by the International Board of Directors. These bodies evaluate the scientific medical merit of the application, the merit of the application, the qualifications, experience and productivity of the investigators, the facilities available, and the relationship of the research to the cause, treatment, prevention and cure of diabetes and its complications.

Completed applications must be received not later than March 1, 1986.□

USING A PATIENT SURVEY?

Have you developed or found a form for obtaining feedback from your patients? If you have, please share it with MSMS. The Public Relations Subcommittee of the Advisory Committee on Communications and Professional Relations wishes to review the forms that are in use, then develop a new one containing the *best* features from *your* samples.

Your comments about your patient survey form are welcome, too. Tell us what you like best, or least, about your version, and what you would do differently. Explain how you distribute forms, and how you evaluate the results.

Please send your sample forms and comments, anonymously if you wish, to Sheri Greenhoe, MSMS, 120 W. Saginaw, East Lansing 48823.

HYPERTENSION

A One-Day Symposium

This symposium will cover a variety of topics including:

- Is Stepped Care Therapy for Hypertension Appropriate in the 1980s?
- Epidemiology of Hypertension
- Renovascular Hypertension
- Management of Patients with Treatment-Resistant Hypertension
- Geriatric Hypertension
- New Developments in Anti-hypertensive Therapy
- Non-pharmacologic Management of Hypertension
- Hypertension in Pregnancy

Among the distinguished speakers will be:
Edward D. Frolich, MD, Vice President,
Education and Research - Alton Ochsner Medical Foundation;
New Orleans, Louisiana
James C. Stanley, MD, Professor of Surgery; Head,
Division of Peripheral Vascular Surgery -
The University of Michigan Medical School;
Ann Arbor, Michigan
Ray W. Gifford, Jr., MD, Vice Chairman, Division of Medicine -
Cleveland Clinic Foundation; Cleveland, Ohio
James R. Sowers, MD, Chief,
Endocrine and Hypertension Division;
Professor, Internal Medicine and Physiology -
Wayne State University; Detroit, Michigan
Stevo Julius, MD, Professor of Internal Medicine and Physiology;
Director, Division of Hypertension -
University of Michigan; Ann Arbor, Michigan
Frank A. Finnerty, Jr., MD, Professor of Medicine -
Georgetown University; Washington, D.C.

when:

Saturday, April 12, 1986
7:30 a.m. to 4:30 p.m.

where:

South Macomb Hospital
11800 E. 12 Mile Road
Warren, Michigan

registration:

advance registration	
physicians	$75
physicians-in-training	$25
allied health professionals	$25
registration at the door	**$80**

Seven hours of Category 1 Credit

For Advance Registration: send check payable to Detroit-Macomb Hospital Corporation Annual Seminar Fund to:

Detroit-Macomb Hospital Corporation
Department of Medical Affairs
7815 E. Jefferson Ave.
Detroit, MI 48214
or call: (313) 821-6000, ext. 270

MSMS, MSMS/A, AMA & MEDICAL ASSISTANTS

March 13 — MSMS/Auxiliary Legislative Day, Prudden Hall Civic Center, Lansing, contact: Viola M. Heins, MSMS headquarters (517)337-1351.

March 14-16 — AMA National Conference on Medical Ethics, Sheraton New Orleans Hotel & Towers, contact: Mary Devlin, AMA headquarters (312)645-4613.

March 19-20 — MSMS Maternal Health Conference, "25 Years of Growth and Change," Hyatt Regency Dearborn, contact: Sherry Fent, MSMS headquarters (517) 337-1351.

March 19 — MSMS Board of Directors Meeting, MSMS headquarters, East Lansing, contact: William Madigan (517)337-1351.

March 26 — MSMS Practice Management Seminar: Advanced Marketing, Kinsley Inn, Bloomfield Hills, contact: Donna Farougi, MSMS headquarters (517)337-1351.

April 9 — MSMS Practice Management Seminar: Medical Practice Collection Management, Hyatt Rengency, Dearborn, contact: Donna Farougi, MSMS headquarters (517)337-1351.

April 11-13 — AMA's Seventh National Conference on the Impaired Physician, Hilton Hotel and Towers in Chicago, contact: Pat Clark, (312)645-4497.

April 17-18 — MSMS cosponsored conference on The Child with Chronic Illness/Disability: A Framework for the Future, East Lansing, contact: Mary Helfer, (517) 353-8856.

April 23 — MSMS Practice Management Seminar: Medical Practice Collection, Marriott Inn, Grand Rapids, contact: Donna Farougi, MSMS headquarters (517)337-1351.

April 30 — MSMS Practice Management Seminar: Advanced Marketing, Marriott Inn, Grand Rapids, contact: Donna Farougi, MSMS headquarters (517)337-1351.

May 2-3 — MSMS House of Delegates, Hyatt Regency Dearborn, contact: William Madigan (517)337-1351.

May 12-14 — MSMS/Auxiliary Annual Session, Grand Traverse Resort, Traverse City, contact: Viola M. Heins, MSMS headquarters (517)337-1351.

May 15 — MSMS Sports Medicine Conference, Clarion Convention Center, Lansing, contact: Sherry Fent, MSMS headquarters (517) 337-1351.

June 27 — Practice Management Seminar: Computers in the Medical Practice, Hilton Shanty Creek, Bellaire, contact: Donna Farougi, MSMS headquarters (517) 337-1351.

July 17-20 — MSMS Midsummer Board meeting, St. Clair Inn, St. Clair, contact: William Madigan (517)337-1351.

August 22 — Practice Management Seminar: Computers in the Medical Practice, Boyne Mountain, Boyne Falls, contact: Donna Farougi, MSMS headquarters (517)337-1351.

OTHER MEETINGS

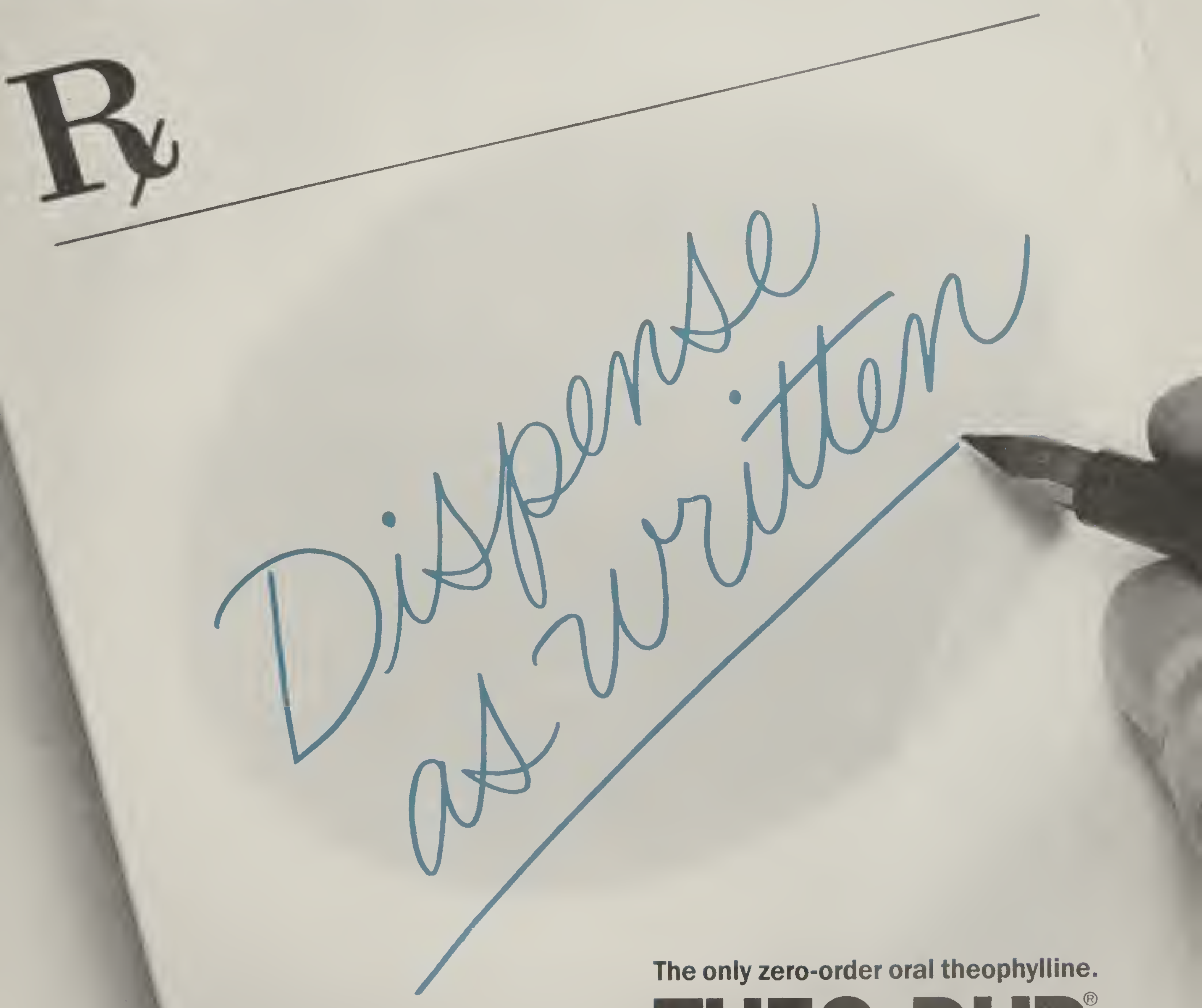
March 19-22 — 1986 Great Lakes Athletic Trainers Association Winter Meeting and Sports Medicine Symposium, Amway Grand Plaza Hotel, Grand Rapids, contact: Lee Kermode, 2317 Gleneagle Drive, Kalamazoo 49001.

May 1 — Michigan Chapter, American College of Surgeons, Coller Day Competition, Omni International Hotel, Detroit, contact: Viola M. Heins, MSMS headquarters (517)337-1351.

May 17-18 — Michigan Society of Pathologists — Immunopathy and Fine Needle Aspiration Lesions, St. Clair Inn, contact: Viola M. Heins, MSMS headquarters (517)337-1351.

In Michigan, Theo-Dur is the only oral theophylline that delivers an essentially equal dose every hour.

But only if you say so.



The only zero-order oral theophylline.

THEO-DUR®
(theophylline anhydrous) Sustained Action Tablets

Please see next page for brief summary of prescribing information

THEO-DUR®
(theophylline anhydrous) Sustained Action Tablets

Today's most widely prescribed bronchodilator.

Description: THEO-DUR sustained action tablets contain anhydrous theophylline, a bronchodilator, in a sustained release formulation (with no color additives) which allows a 12-hour dosing interval for a majority of patients and a 24-hour dosing interval for selected patients.
Clinical Pharmacology: Theophylline directly relaxes the smooth muscle of the bronchial airways and pulmonary blood vessels, thus acting mainly as a bronchodilator and smooth muscle relaxant. The drug also produces other actions typical of the xanthine derivatives: coronary vasodilator, cardiac stimulant, diuretic, cerebral stimulant, and skeletal muscle stimulant. The actions of theophylline may be mediated through inhibition of phosphodiesterase and a resultant increase in intracellular cyclic AMP Apparently, no development of tolerance occurs with chronic use of theophylline.
Indications: THEO-DUR is indicated for relief and/or prevention of symptoms of bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.
Contraindications: THEO-DUR is contraindicated in individuals who have shown hypersensitivity to theophylline or any of the tablet components.
Warnings: Excessive theophylline doses may be associated with toxicity; serum theophylline levels should be monitored to insure maximum benefit with minimum risk. Incidence of toxicity increases at serum levels greater than 20 mcg/ml. High blood levels of theophylline resulting from conventional doses are correlated with clinical manifestation of toxicity in: patients with lowered body plasma clearances, patients with liver dysfunction or chronic obstructive lung disease, and patients who are older than 55 years of age, particularly males. There are often no early signs of less serious theophylline toxicity such as nausea and restlessness, which may occur in up to 50% of patients prior to onset of convulsions. Ventricular arrhythmias or seizures may be the first signs of toxicity Many patients who have higher theophylline levels exhibit tachycardia Theophylline products may worsen pre-existing arrhythmias.
Precautions: THEO-DUR TABLETS SHOULD NOT BE CHEWED OR CRUSHED. Theophylline should not be administered concurrently with other xanthine medications Use with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, in the elderly (especially males) and in neonates. In particular, great caution should be used in giving theophylline to patients with congestive heart failure. Frequently, such patients have markedly prolonged theophylline serum levels with theophylline persisting in serum for long periods following discontinuation of the drug. Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to the G.I. tract although gastrointestinal symptoms are more commonly centrally mediated and associated with serum drug concentrations over 20 mcg/ml.
Individuals who are rapid metabolizers of theophylline, such as the young, smokers, and some non-smoking adults, may not be suitable candidates for once-daily dosing. These individuals will generally need to be dosed at 12 hourly or sometimes 8 hourly intervals Such patients may exhibit symptoms of bronchospasm near the end of a dosing interval, or may have wider peak-to-trough differences than desired
Usage in Pregnancy: Animal reproduction studies have not been conducted with theophylline. It is not known whether theophylline can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Xanthines should be given to a pregnant woman only if clearly needed.
Nursing Mothers: It has been reported that theophylline distributes readily into breast milk and may cause adverse effects in the infant. Caution must be used if prescribing xanthines to a mother who is nursing, taking into account the risk-benefit of this therapy.
Pediatric Use: Safety and effectiveness of THEO-DUR administered every 24 hours in children under 12 years of age, and every 12 hours in children under 6 years of age, have not been established.
Adverse Reactions: The most consistent adverse reactions are usually due to overdose and are:

Gastrointestinal: nausea, vomiting, epigastric pain, hematemesis, diarrhea.

Central nervous system: headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions.

Cardiovascular: palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias.

Respiratory: tachypnea.

Renal: albuminuria, increased excretion of renal tubular and red blood cells, potentiation of diuresis.

Others: rash, hyperglycemia and inappropriate ADH syndrome.
How Supplied: THEO-DUR 100 mg, 200 mg and 300 mg sustained action tablets are available in bottles of 100, 500, 1000 and 5000, and in unit dose packages of 100.
Caution: Federal law prohibits dispensing without prescription. For full prescribing information, see package insert.

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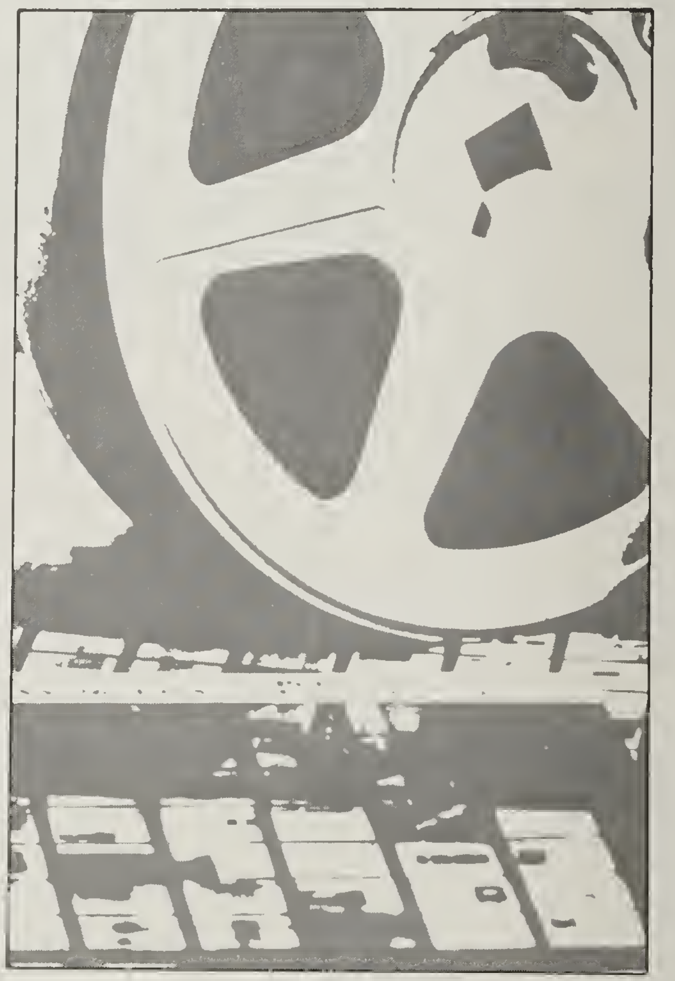

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Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan aw. Sponsors of Category I programs and courses in Michigan are invited to submit nformation for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

Date: February 26, (plus five once-a-week sessions March 5,12,19,26) Chemical Dependency. Location: Detroit. **Sponsor:** Fairlane Health Services Corp. **Contact:** Elaine Hughes, Fairlane Health Services Corp., One Parklane Blvd. Suite 1002-West, Dearborn 48126 (313)271-5502. **Approved for:** 3 hours of Category I Credit.

Date: March 11-12, The Ins and Outs of Critical Care. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Jolene Glaspie, Towsley Center (313)763-1400. **Approved:** 13.25 hours of Category I Credit.

Date: March 12, Dermatology for Primary Care Physicians. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **Approved for:** 8 hours of Category I Credit.

Date: March 14-15, Third Annual Chronic Pain Symposium. Location: Florentine Inn, Saginaw. **Sponsor:** Bay Medical Education. **Contact:** Dodie Roth, Bay Medical Education, 615 Ninth Street, Bay City 48078. **Approved for:** 13 hours of Category I Credit.

Date: March 19, Critical Care and the Pulmonary Practitioner. Location: Kalamazoo Hilton Inn. **Sponsor:** Southwestern Michigan Area Health Education Center and Michigan State Respiratory Therapy. **Contact:** Judy Smith, Pulmonary Services, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001 (616)383-4875. **Approved for:** 5.5 hours of Category I Credit.

Date: April 1-2, Venous Oximetry. Location: Towsley Center, U-M Ann Arbor. **Sponsor:** U-M Medical School. **Contact:** Betty Phillips, Towsley Center (313)763-1400. **Approved for:** 6.25 hours of Category I Credit.

Date: April 3-4, 19th Annual Cancer Symposium. Location: Westin Hotel, Renaissance Center, Detroit. **Sponsor:** Wayne State University School of Medicine. **Contact:** Division of Continuing Medical Education, 4-H University Health Center, 4201 St. Antoine, Detroit 48201. **Approved for:** 11.5 hours of Category I Credit.

Date: April 7-9, Hemodynamic Monitoring and Management. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Dove Margenau, Towsley Center-Box 057, Ann Arbor 48109 (313)763-1400. **Approved for:** 14.25 hours of Category I Credit.

Date: April 10-11, Mechanical Ventilatory Support and Management. Sponsor: University of Michigan Medical School. **Contact:** Dove Margenau, Towsley Center-Box 057, Ann Arbor 48109 (313)763-1400. **Approved for:** 14 hours of Category I Credit.

Date: April 11-13, Tutorial on Level I Myofascial Release Technique. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, MA, Director of Continuing Medical Education, MSU College of Osteopathic Medicine, A306 E. Fee Hall, E. Lansing 48824. **Approved for:** 24 hours of Category I Credit for MDs and DOs.

Date: April 12, Geriatrics Symposium. Location: Mental Health Center, Bay City. **Sponsor:** Bay Medical Education. **Contact:** Dodie Roth, Bay Medical Education, 615 Ninth Street, Bay City 48708 (517)892-1501. **Approved for:** 6 hours of Category I Credit.

Date: April 16, Psych/Med Day. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital **Contact:** Carol Mastroianni, Program Coordinator (313)343-3877. **Approved for:** 8 hours of Category I Credit.

Date: April 17-18, The Child with Chronic Illness/Disability: A Framework for the Future: Location: MSU, East Lansing. **Sponsor:** MSU Department of Pediatrics and Human Development and MSMS. **Contact:** Mary Helfer (517) 353-8856. **Approved for:** 12.5 hours of Category I Credit.

Date: April 23, Cancer Prevention and Early Detection. Location: Genevieve U. & Donald S. Gilmore Center for Health Education, Healthcare Plaza, Kalamazoo. **Contact:** Charles L. Zeller, Jr., MD, SMAHEC, Stryker Center, 4th Floor, 1521 Gull Road, Kalamazoo 49001. **Approved for:** 6 hours of Category I Credit.

Date: April 26-30, Tutorial on Level II Manual Medicine Techniques (Below Diaphragm). Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit for MDs and DOs.

Date: May 2, Tenth Annual Preventive Cardiovascular Medicine & Rehabilitation Symposium. Location: Martin Verzi Auditorium at Borgess Medical Center, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center, Institute for Cardiovascular Health-Borgess Medical Center, American College of Sports Medicine, Michigan Heart Association, American Academy of Family Physicians. **Contact:** Jeffery P. Morgan, MA, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001. **Approved for:** 5 hours of Category I Credit.

Date: May 28-June 1, Tutorial on Direct Action Thrust Manipulative Technique. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit for MDs and DOs.

Date: June 9-13, Principles of Manual Medicine. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine, College of Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit for MDs and DOs.

Date: July 24-25, Coller Penberthy Thirlby Medical Conference. Location: Grand Traverse Resort, Grand Traverse Village. **Sponsor:** Munson Medical Center. **Contact:** Norma Powers, Coordinator of Medical Education, Munson Medical Center, 6th and Madison, Traverse City 49684 (616)922-9544. **Approved for:** 9 hours Category I Credit.

Date: August 1-3, Tutorial on Level II Myofascial Release Technique. Location: Homestead Resort, Glen Arbor. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing (517)353-9714. **Approved for:** 24 Hours of Category I Credit.

Date: September 3, Update '86 — Rehabilitation of Traumatic Brain Injury. Location: Kalamazoo, Michigan. **Sponsor:** West Michigan Physiatry, PC and Southwestern Michigan Area Health Education Center. **Cost: $50. Contact:** Doctor Bryan Visser, West Michigan Physiatry, PC, 252 E. Lovell Street, Suite 363E, Kalamazoo 49007. **Approved for:** 5.75 hours of Category I Credit.

Date: September 13-17, Tutorial on Level I Muscle Energy Technique. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit for MDs and DOs.

Date: September 26-28, Tutorial on Level I Myofascial Release Technique. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 24 hours of Category I Credit.

The rate for each classified advertisement in *Michigan Medicine* is 40¢ per word, with a minimum charge of $20.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

POSITIONS OPEN

MEDICAL DIRECTOR — Planned Parenthood of Mid-Michigan, Ann Arbor, Michigan. A non-profit, preventive health organization which provides medical services to approximately 6,000 patients annually through family planning, abortion, and vasectomy clinics in seeking an Obstetrician/Gynecologist with a primary interest in family planning and preventive medicine to function as Medical Director with clinical responsibilities and general supervision of medical services and research. Candidates who are Board-Certified in obstetrics and gynecology with additional training, experience, and specialization in reproductive health care should apply. Candidates with an MPH are preferred. Contact JoAnne E. Peterson, Executive Director, Planned Parenthood of Mid-Michigan, 3100 Professional Drive, PO Box 3673, Ann Arbor 48106.

SOLO INTERNIST SEEKS GENERAL INTERNIST to help in rapidly growing, fee-for-service practice. Subspecialty interest welcome. Well-equipped office, 100-bed modern hospital, excellent working and living environment. Call or write Robert Shannon, MD, 218 South James Street, Ludington 49431 (616)843-2525.

EXECUTIVE DIRECTOR FOR 500-MEMBER PROFESSIONAL organization with offices in Flint, Michigan. Requisites include Bachelor's Degree and experience in management and public relations. Salary commensurate with education and experience. Direct resume to Genesee County Medical Society, 806 Tuuri Place, Flint 48503.

MICHIGAN — BE/BC PEDIATRICIAN WANTED to join a board certified pediatrician in a well established, highly regarded pediatric practice. The practice serves two general hospitals with almost total range of all specialities locally available. Located along the shoreline of Lake Michigan. Super fishing, sailing, boating 15 minutes from the office; winter skiing a short distance away; excellent schools and family environment. Submit resume to Box 85, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

BOARD CERTIFIED RADIOLOGIST AVAILABLE for locum tenens. Five years of experience after Board. University Fellowship. Experienced in Ultrasound, Nuclear, CT and Special Procedures. Call (313)487-2921.

CARDIOLOGIST. EXCELLENT OPPORTUNITY for a Board Certified or eligible Cardiologist to associate with a progressive Cardiology group in North Central Wisconsin. Modern single community hospital offering all varieties of comprehensive Cardiology and Cardiovascular/Thoracic Surgery Services. Position available now. If interested, send CV to and/or contact D. Joe Freeman, MD, FACC, North Central Heart Clinic, 425 Pine Ridge Blvd., Suite 204, Wausau, Wisconsin 54401. (715)845-NCHC (6242).

FAMILY PRACTIONER WANTED: Excellent full-time opportunity for board certified or eligible Family Practioner to join multi-specialty group practice in NE suburb of Detroit; attractive benefit package. Send inquires and Curriculum Vitae to Box 84, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

GENERAL INTERNAL MEDICINE SPECIALIST WANTED Excellent full-time opportunity for board certified or eligible General Internal Medicine Specialist to join multi-specialty group practice in NE suburb of Detroit; attractive benefit package. Send inquiries and Curriculum Vitae to Box 84, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

OB/GYN — LARGE MULTI-SPECIALTY GROUP practice in metropolitan Detroit area seeks Board Certified or Board eligible OB/GYN. Please contact Mrs. LaLonde at (313)855-3222 Monday-Friday from 9:00-5:00.

LANSING: BOARD CERTIFIED OR RESIDENCY TRAINED Emergency Physician needed to complete five man group at 280-bed hospital. Fee for service with excellent remuneration. Contact: Director, Emergency Department, St. Lawrence Hospital, 1210 W. Saginaw, Lansing 48915.

FAMILY PRACTITIONER OR GP needed for Urgent Care Clinic which is in operation seven days a week, minor trauma, pediatrics. Please contact Mrs. LaLonde at (313)855-3222 Monday thru Friday, 9:00-5:00.

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By Thomas R. Berglund, MD

The battle is far from over

As I told those of you gathered on the lawn of the Capitol on "Rally Day", October 22, it certainly was gratifying to see so much support. Many times in the past some of us have felt rather lonely as we dealt with the legislature on your behalf.

Now that so many of you have taken a first step into the political process I hope it will not be your last. It should be evident that the government is involved in medical matters and it is only appropriate that we physicians become involved in government.

During my twenty years of involvement with MSMS most of my efforts have been spent in the legislative/political arena. MSMS supported the safety plate glass bill, worked to get the lead out of paint, supported passage of the Medical Practice Act, got changes in the generic drug bill, and made significant changes in the Public Health Statute revisions project among others. More recently MSMS led the seat belt project. Always we are working to make Medicaid and other state programs more workable for patients and the practicing physician.

Doctor Berglund, MSMS president-elect and AMPAC chairman, writes this month at the invitation of Richard J. McMurray, MD, MSMS president.

Berglund

However the battle is far from over! All of you must continue to be involved so that we can get our professional liability package passed. We must continue to monitor and act upon the various legislation that effects medicine.

Continue to write to your state representative and senator as well as to the governor. Remember, they respond to large numbers of letters so get your spouses, employees, patients, neighbors and friends involved as well.

If your county medical society has a luncheon or breakfast, meet with your area legislators, take the time to participate and express your concern. Get to know your legislator *personally*.

MSMS has a Physician Legislative Network program. Volunteer to come to Lansing to participate. Many MSMS committees deal with legislation and always are looking for physicians who want to be involved.

Write letters to your local paper in support of our positions. Volunteer to appear on television talk shows. In short, really get involved in the legislative process.

This is an election year and many of us can get involved in the political process. Form a candidate support committee for your legislator or volunteer to hold a coffee or other event for him/her. If your legislator has not been responsive to our (your) needs, go to work for his opponent.

It has long been said that money is the mother's milk of politics. Join your political party (we need support on both sides of the aisle), contribute to your candidate's campaign fund. Join MDPAC. If every one of the over 10,000 physicians sent a personal check for $150 to become a sustaining member, think of the impact we could have!

Now that you have your feet wet, jump in and swim! Support MSMS positions, become involved in legislative efforts, lobby in Lansing and at home and become politically involved—both personally and financially. Together we can have an influence! ☐

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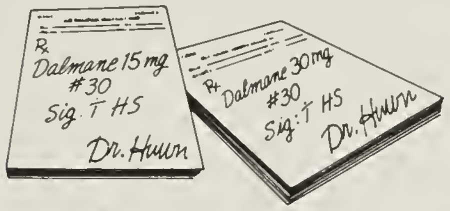

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MICHIGAN MEDICINE

March, 1986 AWARD-WINNING JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 85, No. 3

AIDS

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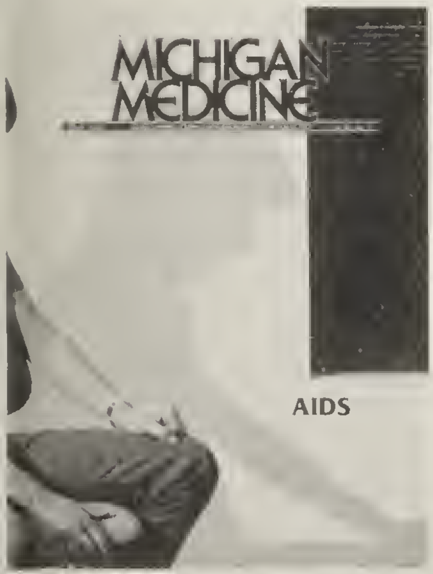

About the cover: AIDS hysteria has made its victims social outcasts. **Photo by Kim Kauffman.**

In next month's issue of Michigan Medicine: An overview of the Michigan Model for Comprehensive School Health Education.

Special report

93 AIDS is a complicated disease complicated even further by society's confusion and hysteria. Physicians who treat AIDS patients are faced with multiple problems — clinical, emotional and ethical. This month's Special Report is a "keeper." It offers insight and suggestions of a recognized AIDS expert on dealing with various aspects of the disease; Evelyn J. Fisher, MD; statistics from the Michigan Department of Public Health.

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By John W. Hall, MD

Arbitration could be streamlined

The use of arbitration has been encouraged as an alternative to a malpractice trial. Indeed, as proposed, it is an attractive solution to many medical care disputes. It has the potential to work faster and more efficiently and thus to lower administrative costs.

However, in practice, the system seems to be bogged down with many of the same problems as the courts. The statute of limitation rules are the same so that the time between the medical event and the filing for arbitration can be protracted. The period of discovery can then stretch out many months. Finally, the establishment of a panel, the clearing of witness lists for conflict of interest and then finding a mutually agreeable date for the hearing will usually take an additional six to twelve months.

I have now had experience with five arbitration cases. I entered into the arbitration system with a very positive feeling and a desire to help make it work. Now, I have my doubts.

Frustrations

My first frustration is with the pace of the system. As a physician, my day is filled with medical events that have to be dealt with — today! Indeed, the entire DRG prospective payment system now tells me to act promptly or lose money.

The legal system has an entirely different concept of time. Extensions are readily given with the not too subtle implication that if more time is not given, then a case has been laid for an appeal. Most cases are like a professional football game — nothing happens until the two minute warning. Prompt and binding deadlines would benefit all. Like an all-nighter before a big test, the few new facts gleaned rarely compensate for the subsequent mental exhaustion. A quicker time frame is definitely needed.

Continued on next page

Doctor Hall, Petoskey, is a member, MSMS Board of Directors, and a member of the MSMS Committee on Publications.

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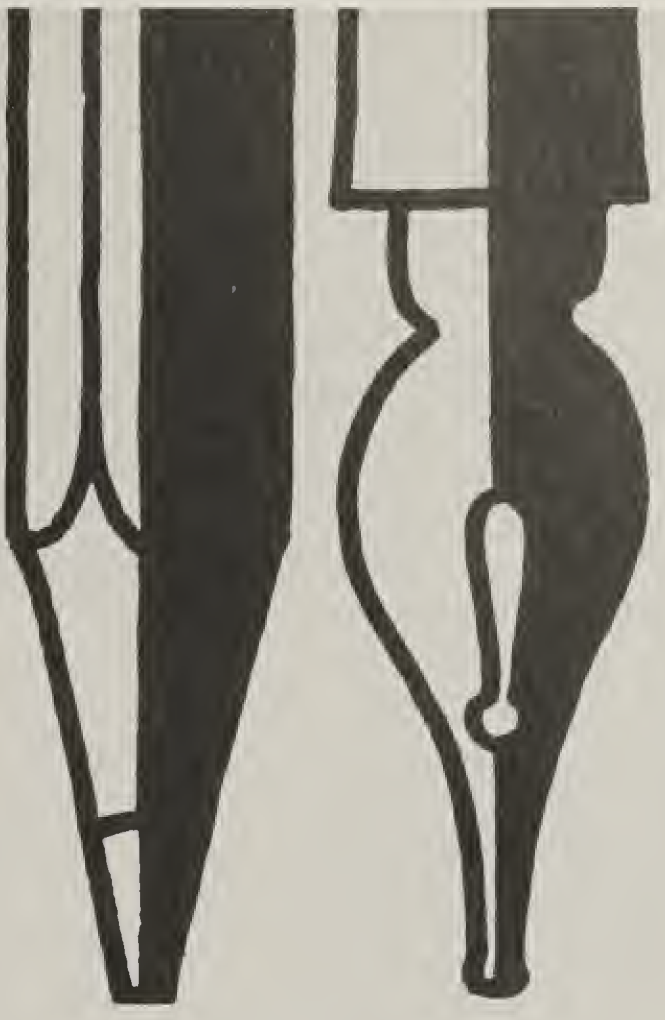
ARBITRATION/Continued

Another major problem in arbitration relates to the role of the panel members. We are relying on those volunteers to make the system work and to arbitrate a solution. Yet, they are shielded from any prehearing contact with the case. Some knowledge of the facts might result in a better prepared panel.

Most panelists take their positions seriously. Office schedules are reworked, travel and lodging plans are made and family responsibilities are altered so that they may serve. Delays, cancellations and settlements serve all parties well except for the soon-forgotten panel members. The payment tendered in no way compensates for the frustrations of trying to play a responsible role in the arbitration system.

Finally, there is a feeling that arbitration is reserved for minor or questionable cases. A pre-trial screening panel would serve an even more important role to clear inappropriate cases out of arbitration. The arbitration process deserves a better chance to succeed and most of the MSMS tort reform package should be applied to the arbitration system as well.☐



Member applauds leaders' efforts on liability crisis

The following letter was received recently by Carl A. Gagliardi, MD, chairman, MSMS Board of Directors:

I would like to just take a minute to write you a brief note and thank you on behalf of our entire department for the tremendous amount of effort that you are putting into the professional liability problem on behalf of physicians in this state. With the projected premium increases that we are about to face over the next six to nine months, I am certain that we will see several more of our physicians leave their practices and move to other states and we will also be seeing established group practices having to split apart because of this sad mess.

As much as I would like to, I find it impossible to keep current with respect to all of the Society's activities in this area. For that reason, it is very reassuring to me personally to receive the *Medigram* every week and through that vehicle to realize the fine work that you and your colleagues are doing on our behalf. Please accept our gratitude and best wishes for the continuing fight.

John R. Musich, MD, Chairman
Department of Obstetrics and Gynecology
William Beaumont Hospital
Royal Oak

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About this Special Report

The articles in this Special Report were prepared by Evelyn J. Fisher, MD, medical director of Wellness Networks, Inc., a Detroit non-profit voluntary agency that operates an AIDS hotline. The hotline, sponsored in part by the Michigan Department of Public Health, is 1-800-482-2404, extension 3582. In Detroit, the number is 876-3582.

Doctor Fisher, of Henry Ford Hospital's Division of Infectious Diseases, has written these articles to help physicians treat *all* aspects of AIDS — physical, emotional and social. She has been recognized as an expert on the disease, and is the MSMS designee to the MDPH Expert Committee on AIDS. For her efforts in the study, treatment, and patient and public education about the disease, the *Detroit News* named Doctor Fisher one of 10 "Michiganians of the Year" for 1985.

By Evelyn J. Fisher, MD

How to combat the AIDS — and FRAIDS — epidemics

AIDS is known to be caused by a virus called HTLV-3/LAV. The virus attacks the key cell in the immune system, the T-helper lymphocyte. AIDS is a sexually-transmitted disease in nature. It is not highly contagious at all, but in fact is fairly difficult to catch. As with other illnesses, a whole spectrum of disease exists in infected persons, ranging from none to fatal disease.

Only the most severe cases cases are being called AIDS and are reflected in the statistics. For every one of the over 15,000 cases of AIDS, there are probably 100 carriers of HTLV-3, which means that there may be one and a half million persons in the US, including 10,000 persons in Michigan, who are infected with this virus at present. Two-thirds of those infected feel fine and are unaware of any problem. They have no symptoms and no abnormalities on routine examination — that is, they do not have lymphadenopathy or low blood counts. Most of the transmission of AIDS is from these healthy carriers.

In addition to the AIDS epidemic, we are facing another epidemic in this country — an epidemic of AIDS-hysteria or a fear of AIDS — which has been termed FRAIDS. FRAIDS has the potential to be even more devastating than AIDS itself. FRAIDS, unlike AIDS, is *very* contagious and *is* transmitted through the air. Medical personnel must be trained to combat the FRAIDS epidemic as well, since it is tremendously wasteful of time, energy and money. It has already caused serious health problems in the United States: a shortage of blood donations, patients refusing to accept blood transfusions, and serious underusage of the valuable hepatitis B vaccine.

Transmission of AIDS

Basically, AIDS is a sexually-transmitted disease with a potential for bloodborne spread in certain circumstances. Either heterosexual or homosexual contact can transmit the disease. Virus is present mainly in semen, blood, and presumably vaginal and cervical secretions. However, female-to-female sexual transmission has not yet

Continued on next page

been documented. In general, men appear to be more efficient sexual transmitters than women (as is true of other sexually-transmitted diseases).

The highest risk type of intercourse is receptive anal intercourse. It does appear that women can transmit the disease to men. In fact, prostitutes may be a significant reservoir of infection in this country and abroad. Currently in the US very few heterosexuals are carriers outside of the drug use and prostitute populations. Thus, the major risk to heterosexuals in this country is sex with intravenous drug abusers, bisexual men and/or prostitutes.

Although the virus is present in small amounts of saliva, tears and possibly urine and feces, the amounts appear too small to be effectively transmitted. Only in situations of intense and prolonged saliva exposure, such as sexual kissing and oral sex, does transmission appear to be possible. The virus has been transmitted through breast milk to infants and through artificial insemination. There is no evidence of transmission through sweat, mosquitos, coughing, food handling, swimming pools, shared toilets, or any other non-sexual social or household contact.

Nosocomial transmission

With regard to nosocomial transmission, to date there has been only one *documented* case of infection via needlestick — that being a British nurse. In the United States, there are several *possible* instances of infection. These consist of three persons who deny being in any of the risk groups and who were found to have positive HTLV-3 serology some months after needlestick exposure. However, in none of these cases was serum obtained prior to or within a few weeks of the time of needlestick to document that there actually was seroconversion. Thus, transmission via needlestick appears to be very rare — unlike hepatitis B, fortunately.

The incubation period for full-blown AIDS (i.e., the time from infection to irreversible immune damage) is very long and may average 3-5 years. Its lower and upper limits are not known. Estimates of the latter range up to 14 years!

Counteracting FRAIDS

In all other situations dangerous to life, panic and hysteria are *not* recommended. Panic does not accomplish anything useful in regard to AIDS prevention. The public and medical profession alike *must* be educated not to react with panic to AIDS. They must learn in what situations they are *actually* at risk, and what are the *appropriate* precautions to take to avoid getting AIDS. Time and money must not be wasted on unwarranted measures such as quarantine.

Gloria Smith, PhD, Director of the Michigan Department of Public Health, has put it very succintly: "People must learn that any individual can virtually eliminate his/her chances of getting AIDS by care in the choice of sexual partners and by not using intravenous drugs."

FRAIDS seems to stem in part from several epidemiologic misunderstandings by the public and many physicians. The following are the reasons why scientists who have studied the issue believe AIDS is not transmitted by non-sexual close personal contact:

1. Although full-blown AIDS has a long incubation period, patients infected with HTLV-3 become potentially contagious *within a few weeks* of getting infected. Thus, all the contacts have been exposed to the virus for a long time before the patient becomes ill. In fact, long-standing contacts have gone through virtually the same incubation period as the patient. Thus, the absence of full-blown AIDS in these contacts is very meaningful.

2. The CDC statement, "AIDS is not spread by *casual* contact," really refers to *non-sexual close personal contact*. In other words, the sort of contact one has with one's family, other household members, friends and co-workers. This contact includes such intimate behavior as sharing bathrooms, food, beds, swimming pools. Most of us would refer to this as "social contact" with the understanding that this includes some fairly intimate contact, but not sexual contact.

3. There has been no transmission of AIDS or even seroconversion of HTLV-3 documented among any of the social contacts of AIDS patients. This means that there are *no* family members, friends or co-workers who have caught AIDS from patients except through sexual contact. Such contacts must number in the hundreds of thousands since there have been over fifteen thousand cases of full-blown AIDS in the United States. This is to say nothing of the contacts of the estimated one and one-half million carriers in the US. Likewise, there has not been any transmission of AIDS from patients to health-care workers (doctors, dentists, nurses, etc.), despite the very close personal contact, with the exception of a few rare needlestick instances. Sometimes this patient contact involves ongoing contact minus any special precautions, before the diagnosis of AIDS becomes known. From this we can see that the routine care we use in dealing with patients in the United States is enough to prevent transmission of AIDS in virtually all instances. Thus, the special precautions ("Blood and Body Fluid Precautions") being recommended deliberately err on the side of

being *overly* careful.

4. Of the people who are classified as "None of the Above; Other" in CDC statistics, many are Haitians (since Haitians were officially removed from the risk groups some time ago), some are from Central African countries where AIDS is endemic in the general heterosexual population and some are persons who died before information could be gathered. Of the others, about 100 or so have been interviewed in depth. All deny even knowing anyone with AIDS. Indirect evidence suggests that these are people who are either not truthful about the risk factors (which is understandable with such sensitive subjects as homosexuality and drug abuse) or people who were unknowingly exposed through sexual contacts with people with these risk factors.

5. The critical distinction between what sort of transmission is theoretically possible and what is *actually* occurring is often misunderstood. Making this distinction is, in fact, the job of the science of epidemiology. Thus, although the AIDS virus may be isolated in small quantities from tears or saliva, this is not to say that tears or saliva transmit AIDS. In fact, the evidence would suggest the contrary. So, despite the many theoretical scenarios that anyone can imagine involving cuts on one's hands, coming in contact with tears, saliva, blood, etc., of other persons, there has been absolutely no evidence of the virus being transmitted in this way. If transmission ever does occur under such circumstances it must be very rare. So, it is not warranted to severely abridge the civil rights of infected persons by denying them employment, quarantining them, or regarding them as "lepers."

In conclusion, the strongest evidence against AIDS being transmitted through non-sexual, non-needlestick contacts is the total absence of AIDS or even seroconversion among such contacts, both among family and friends and health care workers.☐

Consider the psychosocial consequences of AIDS

Psychosocial consequences of AIDS for both patients and physician are enormous. First, physicians must confront within themselves both the prejudice against homosexuals and IV drug abusers, and the irrational fear of contagion that we all have. The IVDA prejudice is more overt, the homosexual more deepseated. Homophobia — the fear of and prejudice against homosexuals — is extremely prevalent and is probably a greater obstacle for male physicians than for female. It can lead to inhumane treatment of persons who already are suffering terribly. The subconscious fear of contagion is something physicians must strive consciously and rationally to overcome. In this, physicians must set the example for other health-care workers.

The psychological stress of AIDS for patients is unbelievable. In addition to facing death, many face abandonment by family, friends and other care-givers, and losing their jobs.

Even persons who appear to be handling things well are almost never able to follow through on their own with the complicated procedures necessary to get on Medicaid or Social Security.

Stress and suicide

The greatest stress actually occurs in those who are infected, but do *not* have full-blown AIDS. The uncertainty about one's future is more stressful even than the terrible certainty of full-blown AIDS. Thus, suicide is more frequent among patients with seropositivity, lymphadenopathy, ARC, "pre-AIDS", etc., than among patients with full-blown AIDS. Finding out that one is likely infected with HTLV-3 is psychologically devastating. The effect on the patient's life is consistently much more profound than patients have anticipated — "catastrophic" is a term patients often use. The common psychological reactions (not necessarily in this order) include shock, denial, guilt, fear, anger, depression, bargaining, and in some, ultimately acceptance.

Compounding the problem is the encephalopathy that is seen in up to half of the patients with AIDS and in some who do not have full-blown AIDS. This can result in cognitive and emotional problems, as well as in sensory and motor deficits. The AIDS virus itself is neurotropic and is most likely the cause of

Continued on next page

most of these encephalopathies. Ten percent of patients become very demented and unable to speak or walk.

So, physicians must anticipate problems. Physicians must counsel patients before testing for HTLV-3 or diagnosing AIDS. They must determine who the patient's support system(s) is or are, and promptly refer the patient to social workers and to counselors. Local AIDS organizations can often assist. One can call local health departments or Wellness Networks, Inc. to see if there is an organization in the area. These organizations can often assign a volunteer to be a "buddy" for the patient. Family, lovers and friends need counseling also, especially those who will be living with the patient. These people also need to talk with infection control personnel about how to handle things at home.

Confidentiality

Medical confidentiality is, at best, a loose concept in these times. However, with this infection which can make a person a total outcast — a "leper" in every sense of the word — physicians must make special effort to ensure that they and their staff do everything possible to maintain confidentiality.

Physicians must expect that dealing with HTLV-3-infected persons is going to be time-consuming, stressful and even minimally hazardous (due to the rare occurrence of infection after needlestick). Dealing with AIDS requires three of the physician's most prized qualities: rationality, compassion and moral commitment. Hopefully, some physicians' deficiencies in one more of these qualities can be overcome so that we can all work together to fight the twin epidemics of AIDS and FRAIDS.☐

HTLV-3 produces a

The spectrum of illness due to HTLV-3 is broad, ranging from none to fatal disease. Fatal disease is called "full-blown AIDS" or "CDC-AIDS."

In addition to these, a number of other manifestations have been recognized. Particularly important among these are progressive neurologic disorders due to HTLV-3 itself, certain high-grade B-cell lymphomas, and an acute self-limited infectious mono-like illness.

Symptoms

The spectrum of AIDS illness ranges from none to severe. Symptoms, signs and laboratory abnormalities which may be seen in the milder forms of infection include fatigue, weight loss, fever, night sweats, diarrhea, lymphadenopathy, thrombocytopenia, leukopenia or anemia. More severely ill persons may have cough, dyspenea on exertion, white patches in the mouth (thrush) and red or purple spots on the skin (Kaposi's sarcoma). As can be seen, none of these manifestations are in any way specific or unique to HTLV-3 infection. In fact, in persons not at high risk, the odds of any of these manifestations being due to HTLV-3 is vanishingly small.

In screening for AIDS, physical examination with attention to lymph nodes, skin, mouth, ano-genital region and spleen is advised. For seriously ill patients, examination of the optic fundi is also indicated to look for exudates and hemorrhages (cotton wool spots or cytomegalovirus retinitis). The laboratory work that is recommended includes the HTLV-3 serology (see "HTLV-3 antibody tests" below), CBC with differential and platelet estimate, urinalysis, skin test for TB and at least two control skin tests for anergy. If any abnormalities are found (such as any cytopenia or anergy) further testing is in order. If the patient is a contact of someone with HTLV-3 infection, repeat the HTLV-3 serology at three-month intervals over one year. Based on a small number of cases and animal data, it appears to take two to three months for serology to become positive after exposure in most persons. However, a few persons seem not to develop antibody over even longer intervals. Since many persons at increased risk for AIDS are also at increased risk of hepatitis B and syphilis, these serologies are often indicated also.

HTLV-3 antibody tests

At present, only antibody tests are available. The one generally available is the HTLV-3 ELISA Antibody Test.

Tests to detect the presence of the virus itself (by culture or antigen detection) are not presently available. Only certain research laboratories have been able to perform cultures on very small numbers of persons in experimental situations. Even when such tests become available, if they do, they will probably not be very sensitive — that is, while a positive will indicate active infection, a negative will not rule it out.

The experimental data to date suggests that most persons who are antibody-positive are still actively infected and

By Evelyn J. Fisher, MD

broad range of illness

potentially contagious. Therefore, for now, antibody-positive persons must be assumed to be culture-positive. Thus, the antibodies detected in HTLV-3 testing do not in most cases indicate immunity. Rather, they are similar to the VDRL — that is, they co-exist with active infection.

False positive and negative ELISA tests occur. This is true of any screening test. To estimate whether a person's ELISA is likely to be a true positive or negative, several factors must be taken into account:

1) Risk of infection in this particular patient. The statistical formula Bayes Theorem indicates that the *predictive value* of a positive or negative test *is dependent upon the prevalence of the disease in the population tested.* This works out to mean that in persons at low risk, the main problem is false-positives, whereas, in persons at high risk, the main problem is false-negatives. For example, in blood donors most positives are false-positives; on the other hand, in gay men with many partners, there is up to a one-third chance that a negative is a false-negative.

2) The repeatability of the ELISA result. In general, the ELISA test should be repeated on another day in persons who test positive and also in high-risk persons who test negative. If the test is repeatedly positive in a high-risk person, the result is most likely valid.

3) The degree of positivity of the ELISA. If the person's result in ELISA unit is five to seven or more times the control for the same run, it is very likely to be a true positive.

4) Positive result by another method of antibody testing. Most commonly, this is via the Western Blot (an immunoelectrophorectic method) which is done by some referral labs and the state health department. The Western Blot is probably more specific but less sensitive than the ELISA. Although the Western Blot is sometimes referred to as "confirmatory," it must be realized that *there is no gold standard for HTLV-3 testing at the present.* All we can say is that persons who are both ELISA and Western Blot positive are extremely likely to be true-positives.

In general, low-risk persons should not be screened since a positive is most likely a false-positive in the case of low-risk persons. The only exception to this is the screening of donors of blood, organs, semen, etc., or the performance of epidemiologic studies. In the American Red Cross screening program, the Western Blot is done also and only donors who are both ELISA and Western Blot positive are informed of their seropositivity. This is not always true of other screening programs. The inadvisability of screening low-risk persons means that is is not advised to screen household, work or social contacts who are not sexual partners (except for children born at a time when the mother may have been carrying HTLV-3). Likewise, general screening of employees is not advised. This is because in such situations, again, most positives would be false-positives and an enormous amount of time and money would be required for further testing, counseling, dealing with psychological damage and the resultant civil rights problems. Since AIDS is not being transmitted in situations of social non-sexual contact, the expenditure of time and money on this is very wasteful.

Screening candidates

Persons who are candidates for screening are those at high risk. This includes those with the following risk factors since 1978: homosexual or bisexual men with multiple partners; intravenous drug abusers; hemophiliacs, especially those on home therapy; patients who have immigrated from Haiti since 1978; very promiscuous heterosexuals, including prostitutes and their customers, and the sexual partners and infants of any such persons.

In general, other transfusion recipients should not be screened. The only exceptions would be those who: 1) have received transfusions from donors known or suspected to be carrying HTLV-3; and 2) those who have signs or symptoms suggestive of AIDS. It is important to keep in perspective that the risk of AIDS from blood products is extremely low, except in pooled products made from large number of donors prior to March, 1985. In March, 1985 most blood collecting facilities began to use HTLV-3 serology for screening. Since 1983, most hemophiliacs have been receiving plasma factors that have been heat-treated which renders them non-infectious for HTLV-3.

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HTLV-3/Continued

For single unit products, the risk of infection can be calculated to be at least six times less that that of fatal viral hepatitis from the same unit. Since approximately one in every three thousand southeastern Michigan Red Cross blood donors is seropositive and the test detects about 95 percent of carriers, the risk in a single unit is, at most, one in 60,000. To date there has been only one possible case of non-hemophiliac transfusion-associated AIDS in Michigan. Nationwide, there has been no evidence of transmission from gammaglobulins to date. The hepatitis B vaccine has proved to be perfectly safe.☐

Education is key to

AIDS preventive efforts need to concentrate on education of high-risk persons, as well as education of all sexually active persons. In high-risk persons, HTLV-3 antibody screening may serve a useful purpose. However, the AIDS Antibody Test must not be treated like any other test. Patients must be advised of the potential consequences of the test and give consent to being tested. Pre-test counseling is mandatory regarding 1) the limitation of the test (i.e., the potential for false-negatives and false-positives); 2) the devastating psychological effects of a positive test; 3) the potential problems regarding insurability; 4) the civil rights issues; 5) other potential problems from loss of confidentiality, such as the "leper syndrome." The state of AIDS-hysteria in this country is such that it would be very difficult for someone to maintain a job, schooling and housing should his/her infection become general knowledge.

Physicians should make patients aware that there are three ways to get the HTLV-3 ELISA test done. These methods vary in the degree of confidentiality:

1) Least confidential: As a regular test through the physician's regular or hospital laboratory.

2) Semi-confidential: The physician replaces patient's name with a code number and sends coded specimen to the regular laboratory. Legally, the physician should then write the result of the test in the patient's medical record.

3) Completely confidential: The Alternative Site Testing Program (so-called because it was originally devised to keep people from donating blood just to find out the results of their HTLV-3 serology). This confidential program is available at several locations in Michigan. Patients must call Wellness Networks, Inc. for details and pre-test counseling: (Detroit (313) 876-3582; Michigan (toll free) 1-800-482-2404, ext. 3582; US outside Michigan (toll free) 1-800-521-7946, ext. 3582).

The results of the test in this

the battle against AIDS

system are given only to the patient and will not go into any medical record and are not sent to the physician. (Of course, the patient may inform the physician of the results if the patient wishes.) The only drawback of this system is that currently only the ELISA test is being done. Hopefully, the Western Blot will soon be available for those who are ELISA-positive.

At the present time a positive HTLV-3 serology is not a reportable condition in Michigan. Only persons with full-blown AIDS are required to be reported to the health department.

Concerns about the test

The gay press has been very much against the HTLV-3 antibody test, due in part to legitimate civil rights concerns and in part to misinformation about the accuracy of the test. The facts are that the test, if done and interpreted properly, is the best predictor of the probability of infection that we have now and the best that we are likely to have for some time. Since two-thirds of carriers are normal on physical exam and routine laboratory testing, there is no other way to let the majority of carriers know about the potential problem. I have found the test to be the strongest motivator of behavior change in the at-risk persons — changes to help save the person's own life *and* the lives of others. However, as stated previously, it is not a test to be undertaken lightly or without a patient's or a person's informed permission. To have to deal with the reality of being infected with HTLV-3 is catastrophic psychologically and a few people have committed suicide over the results of this test alone.

Suspected co-factors

It is strongly suspected that four other factors beyond mere contact with HTLV-3 influence both likelihood of infection if exposed, and the likelihood of disease if infected. Although we do not yet have definitive proof of the role of these co-factors, to disregard them seems foolish, especially in light of what we know about the infections, since all but the first one are potentially modifiable.

1. **Genetic factor**. Most likely some persons will turn out to be more susceptible to HTLV-3 than others, but at present we have no way of identifying such persons or doing anything about this.

2. **Dose and frequency of exposure**. Persons exposed to large amounts of virus and those who are repeatedly exposed to the virus are likely to be at much greater risk.

3. **Underlying immune suppression due to other conditions**. Other causes of immune suppression are common in most of the high-risk groups. Well-known are factors such as excessive stress, poor nutrition, improper rest and use of drugs and alcohol. In addition, the neonate is very immature immunologically. Finally, parenteral exposure to the foreign tissue (HLA) antigens of other persons is immunosuppressive — for example: transfusions are immunosuppressive per se (and are deliberately used as such in renal transplantation!) and semen is immunosuppressive when absorbed into the blood stream, which is more likely to happen with rectal intercourse that with other types of intercourse.

4. **Chronic infection with other microbes**. In multipartnered gay men, drug users and transfusion recipients, exposure and reexposure to such infectons are common — e.g., hepatitus B and non-A and non-B, cytomegalovirus and Epstein Barr virus. In Africa, malaria and possibly other tropical diseases may play such a role as well. These infections do two things: 1) they cause some degree of immune suppression for months, and 2) they cause many T-helper cells to be in the "activated" state, a state in which they are much more susceptible to HTLV-3 infection.

These co-factors have been mentioned in detail because most of them can be changed to help prevent infection in those not infected and to improve the chances of those already infected. A fatalistic attitude — "Well, I'm (probably or definitely) already infected, so it doesn't matter what I do" — is to be decried. Patients must be informed that avoiding further exposure and going on a "real health kick" are very likely to be beneficial as the body wages its ongoing war against this virus.☐

Editor's note: Order up to 200 free "AIDS Update" brochures for your patients from the MSMS Department of Communications and Professional Relations.

By Evelyn J. Fisher, MD

Here are guidelines for AIDS management

Basically, patients with AIDS should be followed, if possible, by an internist with access to consultation with Infectious Diseases, Oncology, and, in some cases, Immunology. Consultations (formal or by phone) with physicians experienced in care of AIDS can be most helpful. At present, physicians at the large institutions in southeastern Michigan have had the most experience — Henry Ford Hospital, University of Michigan and Wayne State University, in particular.

Advice to infected persons

If a patient is seropositive repeatedly or is positive by two different methods, or is diagnosed with CDC-AIDS, the patient should be told that he/she must assume they are *still* infected. This has two implications:

- Their body is still fighting the infection;
- They are potentially contagious to others. Therefore, patient should be told the following:

1.) To try to keep the mind and body in the best possible shape (see "Suspected co-factors" on page 99.) The physician should assess the patient's status in regard to nutrition, exercise, rest, stress management, alcohol, smoking, drugs, and avoidance of further doses of the AIDS virus, or other sexually and IV transmitted infections. The physician should assist the patient in seeing where improvements can be made.

2.) To avoid transmitting infection to others, the patient should be informed regarding sexual precautions (based on present knowledge of the safety of different sexual practices):

No risk: Mutual masturbation (provided saliva is not used as a lubricant and there are no open sores on hands or genitalia); massage and kissing of other non-ano-genital, non-oral areas of body.

Low risk: Sexual kissing; vaginal or anal intercourse using condom and nonosynol-9 containing lubricant; oral sex performed on male wearing condom.

Moderate high risk: Unprotected vaginal or oral intercourse without ejaculation.

High risk: Unprotected oral, vaginal or anal intercourse with ejaculation, of which anal intercourse carries by far the greatest risk.

3.) Basic precautions at home and work: wash dishes in hot soapy water before others use them; do not share items that may draw blood, e.g., razors, toothbrush and, of course, IV drug needles and cookers; clean up spills of blood or body fluids with 1:10 dilution of fresh Clorox.®

Prognosis

We do not know what percent of persons infected with the AIDS virus will eventually develop fatal illness over a lifetime of infection. We only know that the short term outlook for the majority is good — over a two to four year period only five to twenty percent have progressed to full-blown CDC-AIDS. Full-blown AIDS is a fatal disease with average survival of nine months for those presenting with opportunistic infection and one and one-half years for those presenting with Kaposi's sarcoma. However, for every one with full-blown AIDS, there are many more carriers.

Infection control precautions

First of all, it should be pointed out that the routine standards of hygiene, without special isolation precautions practiced in the hospitals and doctors' offices in this country, have been enough to prevent transmission in all but rare instances of needlestick exposure. Although the special "Blood and Body Fluid Precautions" (same as for hepatitis B) currently are recommended, it must be realized that these are, for the most part, overly careful. There has been no instance of transmission of HTLV-3 (outside of needlesticks, rarely) to doctors, including endoscopists, to dentists, to nurses, or to laboratory personnel, etc., even though no special precautions were used. Many thousands of persons carrying HTLV-3 have undergone medical and dental care in this country without any isolation precautions being used as their infection was not recognized at the time.

Failure of HTLV-3 to be transmitted in most situations is probably due both to dose (not enough virus is present and survives outside the body) and the fact that the virus is readily inactivated by most

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MANAGEMENT/Continued

common disinfectants. Five- to ten-minute exposures to the following agents and commonly used dilutions are enough to kill the virus: chlorine (1:10 dilution of household bleach such as Clorox), alcohol, hydrogen peroxide, phenol (such as Lysol) and iodine, as well as stronger disinfectants such as gluteraldhyde (Cidex, etc.), formalin, heat (boiling or pasteurization), and all sterilizing measures (autoclaving, gas, etc). The virus also is killed by the spermicide nonoxynol-9.

The virus can survive freezing and small amounts can survive in dry state for a number of days. However, the amounts that survive in the environment do not seem to be enough to infect persons. The only dried virus that has proved infectious is that present in clotting factor concentrates which, of course, are rehydrated and injected intravenously.

Blood and body fluid precautions in the office mean the use of gloves for examining mouth and ano-genital areas and for drawing blood. Further precautions (gown, mask and goggles) are necessary only when there is a possibility of contaminating clothes with or aerosolizing large amounts of blood and other body fluids — e.g., during suctioning, endoscopy, surgery, dental procedures and autopsies.

Again, around the home, the main precautions are that 1) dishes be washed in hot, soapy water before use by others; 2) that patients not share items that might draw blood (e.g., razors, toothbrushes); and 3) that spills of blood or body fluids be cleaned up with 1:10 dilution of fresh household bleach. A full list of household precautions is in the publication "Lifestyle Guide For Patients With AIDS, Suspected AIDS or Lymphadenopathy Disease" and dental precautions are in the publication "Dentristry and Oral Surgery Guidelines for Care of Patients with Hepatitis B or AIDS." A copy of each of these articles is available from Wellness Networks, PO Box 1046, Royal Oak 48068 (313) 876-3582.

Even without such precautions at home, it must be reiterated that there has not been transmission of HTLV-3 in US households with just routine hygiene. The pragmatic observation of no transmission in typical household situations should be very reassuring.☐

Michigan Department of Public Health Acquired Immune Deficiency Syndrome (AIDS) Statistics (as of February 10, 1986)

Cases & deaths by year diagnosed

Year	Cases	Deaths
1981	2	2
1982	2	1
1983	12	10
1984	40	26
1985	65	24
1986	5	1
Total	**126**	**64**
Males	121	
Females	5	

Cases by age

Age	Cases
0-19	2
20-29	35
30-39	54
40-49	23
50+	12

Cases by race

Race	Cases
Black	56
White	67
Hispanic	3
Other	0

Cases by risk group

Male homo/bisexual	85	Unknown or non (Total)	7
Intravenous drug user	12	Interviewed no risk	(3)
IV drug user & homo/bisexual	13	Died before interview	(1)
Heterosexual contact to high risk	2	Investigation pending	(2)
Hemophiliac	5	From country where most cases have no risk	(1)
Transfusion-associated	1		
Pediatric*	1		

*Epidemiologic data suggest transmission from infected mother to child before, at, or shortly after birth.

Cases by county

County	Cases	County	Cases
Berrien	1	Livingston	1
Branch	1	Macomb	3
Calhoun	2	Monroe	1
Cass	1	Muskegon	1
Genesee	4	Oakland	20
Grand Traverse	1	Ottawa	1
Ingham	4	Saginaw	2
Ionia	2	St. Clair	1
Kalamazoo	2	Washtenaw	6
Kent	3	Wayne	12
Lapeer	1	(Detroit)	56

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By Mary Anne Ford and
Deborah Zannoth

Some aspects of PA 350 will affect physician practice

Public Act 350 of 1980, the Nonprofit Health Care Corporation Act, represents a complete revision of the BCBSM enabling legislation. Until now, BCBSM has operated under legislation adopted in 1939. Shortly after PA 350 was enacted, BCBSM entered into a court challenge over the constitutionality of parts of the new law. A court order prohibited the state from enforcing PA 350, and the matter was in litigation for nearly five years. On April 16, 1985, the Michigan Supreme Court ruled the questioned parts of the act constitutional and directed BCBSM to begin implementation of the law.

The law is extremely extensive and addresses numerous issues, some which directly affect physician practice in Michigan. This article will examine some of these issues.

PA 350 states that the purpose and intent of the law is to promote appropriate distribution of health care for all Michigan residents and to assure reasonable access as well as reasonable cost and quality of health care. PA 350 also provides for the regulation and supervision of this law by the insurance commissioner and the state's Attorney General. Regulation of BCBSM under PA 350 extends into nearly every area of the Blues' activity: payments to providers; cost containment programs; reserving practices; subscriber rates, and corporate activity. The new law also contains specific provisions regarding the composition of the BCBSM Board of Directors. Under these new regulations, the insurance commissioner and the Attorney General are given unprecedented regulatory powers, especially with regard to the Blues' Board of Directors and their cost containment activities.

Ms. Ford is chief, MSMS Section on State Government Affairs and Ms. Zannoth is assistant, MSMS Department of Medical Economics and Health Care Delivery.

Board of directors

PA 350 reduces the number of individuals on the board from 47 to 35 and the number of provider seats from 17 to eight. Of the remaining 27 seats, 22 must represent subscriber groups, four must be public representatives appointed by the Governor (two of whom are retirees), and one may be an officer or employee of the corporation. The eight providers on the board must include one representative of physicians, hospitals, pharmacists and registered nurses. Other provider directors must be as broadly representative of provider classes as possible.

In order for implementation of a board reorganization to begin, the law requires that a board reorganization plan be approved by the Attorney General. A plan recently submitted for approval provides for three physician representatives, including two allopathic physicians and one osteopathic physician. The plan is currently in litigation because of objections raised by the Attorney General over the proposed time frame for reorganization and the proposed methods for choosing individuals to serve on the board.

Per case participation

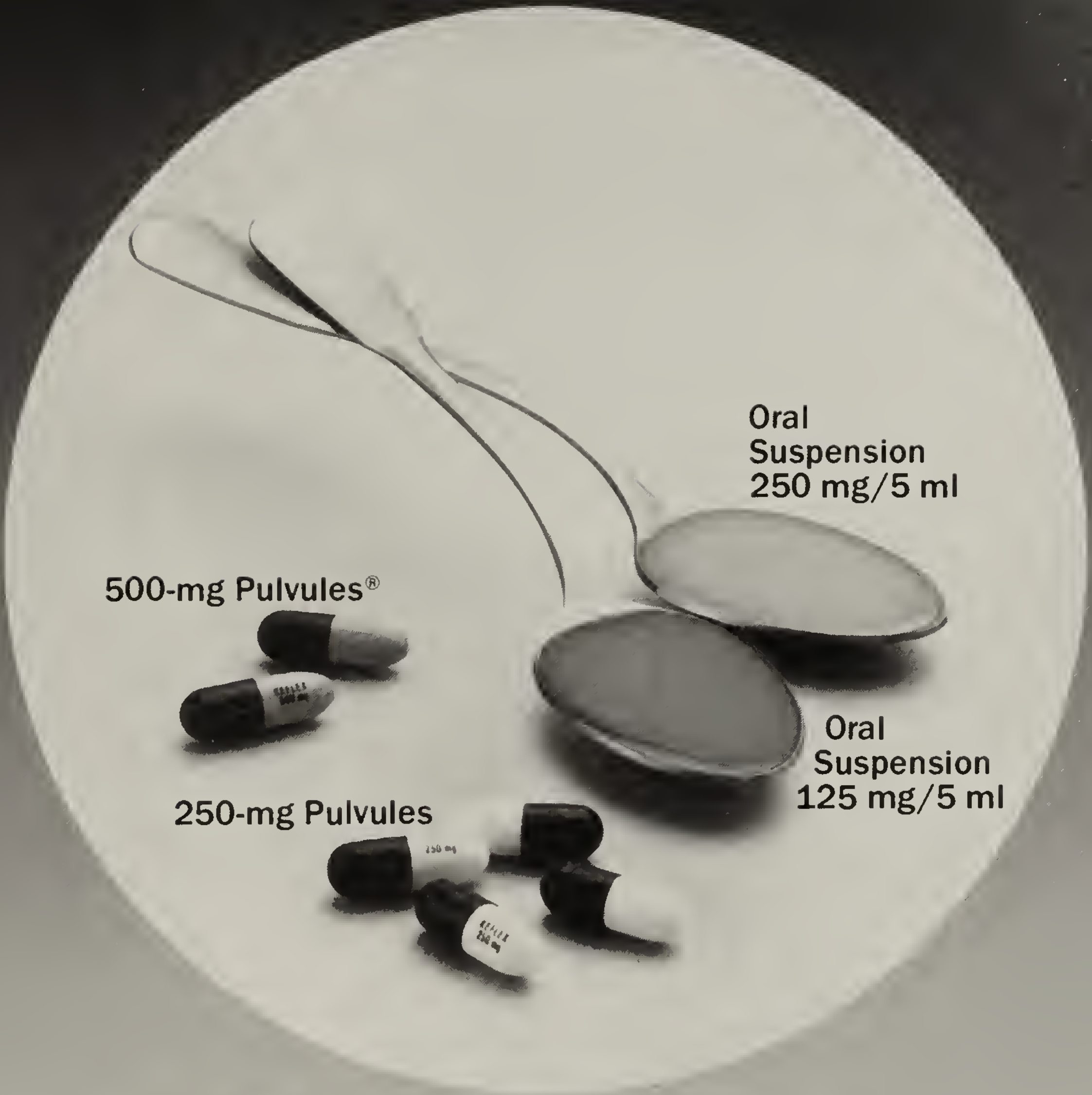
The bill allows for the continuance of the per case participation option among physicians under the following conditions: If the provider accepts payment and participates on a specified procedure, then he or she must participate for all cases involving the procedure specified for the duration of the calendar year. BCBSM has notified all physicians in the state of the per case participation language, and MSMS has requested clarification of this section.

Cost containment plans

PA 350 requires the corporation to submit to the insurance commissioner provider class plans as a mechanism for containing costs. The provider

Continued on page 114

Easy To Take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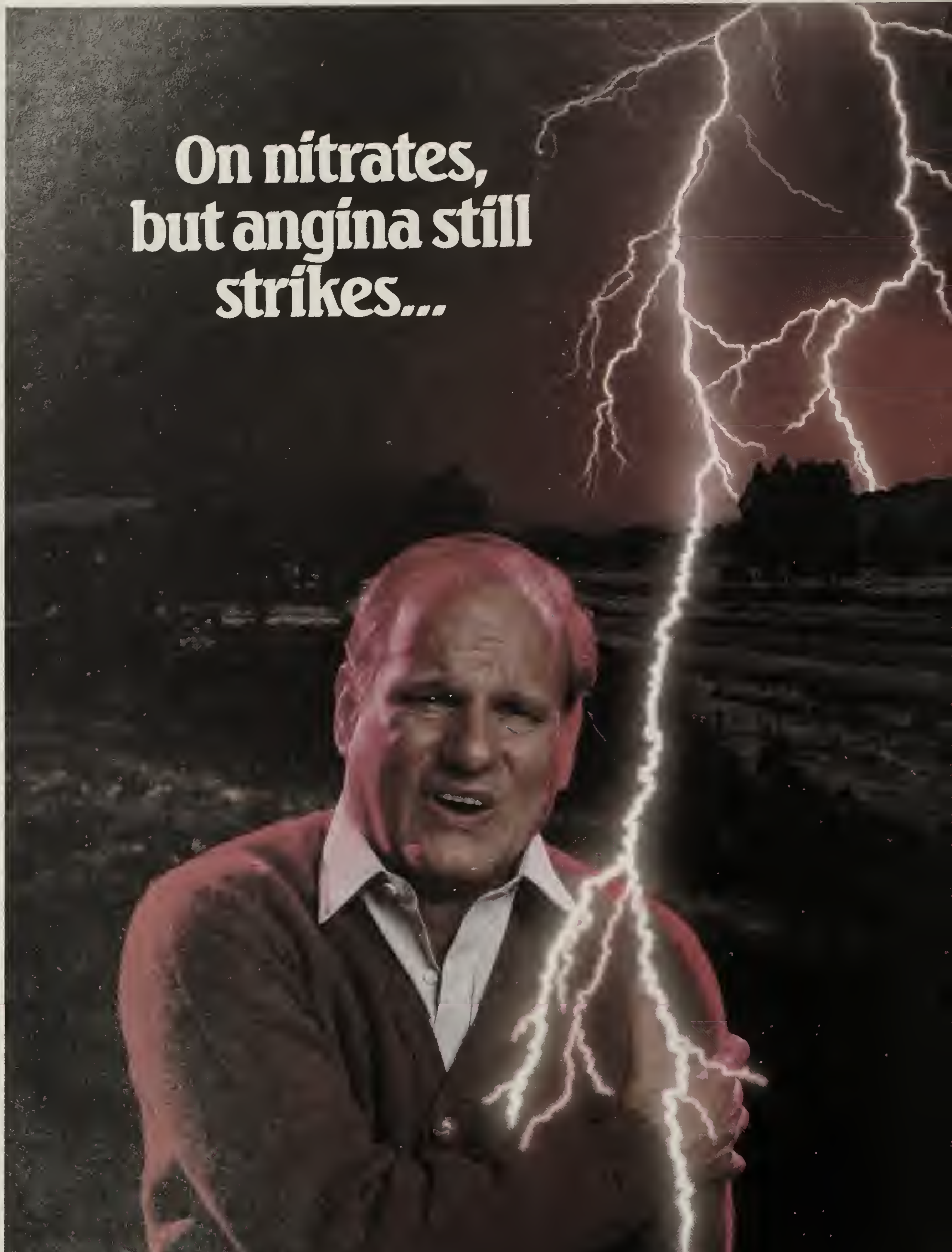
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but angina still
strikes...

After a nitrate, add ISOPTIN®

(verapamil HCl/Knoll)

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First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin...for more comprehensive antianginal protection without side effects which may cramp an active life style.

ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

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Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.*) Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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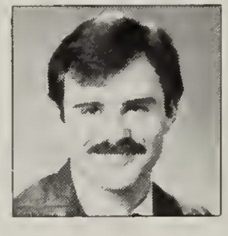

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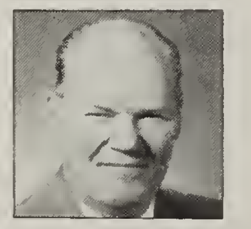

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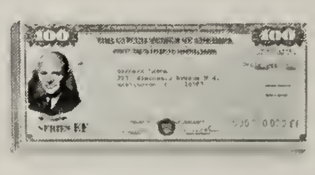

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BALANCED CALCIUM CHANNEL BLOCKADE!

CARDIZEM
(diltiazem HCl)
balances potent coronary vasodilation with a low incidence of side effects

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes (*P*<.005).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page.

2/84

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*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

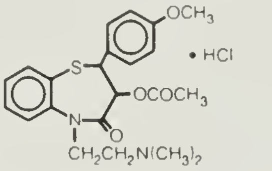
References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect, cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

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By Katharine S. Brown

Consider a simplified employee pension program

Are you frustrated by the additional reporting procedures the Keogh plans must now follow? Did you fail to establish a Keogh by December 31?

If your answer is "yes" to either of those questions, ask your tax advisor about a Simplified Employee Pension Program (SEP). A SEP is a qualified plan established by the employer (who may or may not be incorporated). The employer's contribution is placed into an employee's Individual Retirement Account or Individual Retirement Annuity (IRA). For the 1985 tax year, the deductible contribution limits are 15 percent of compensation or $30,000, whichever is less.

The employer's contribution to the SEP-IRA may vary from year to year. The employer is not required to contribute for any year. When the employer does make a contribution, the same percentage of pay is contributed for all employees. Employer contributions are not subject to income tax withholding, FICA or FUTA deductions. The SEP contribution is included in the employee's gross income on Form W-2 and must be claimed by the employee as an offsetting deduction. Remember, participants are entitled to make an additional voluntary tax-deductible IRA contribution of up to $2,000. A SEP-IRA for calendar year 1985 may be established and funded as late as April 15, 1986.

Simplicity

Let's consider the simplicity of establishing a SEP. A simple IRS Form 5305-SEP has to be completed. This constitutes the plan. No federal filing of this document is required. A copy of the completed form is given to each employee; the original is kept in the employer's files. It is the employee's responsibility to establish his own IRA account by completing the necessary application. Once the employee has established his IRA, the employer makes the SEP contribution to that account. Establishing a SEP is just that simple.

Generally, all employees are eligible who are at least 25 years of age and have worked for the employer during three of the preceding five calendar years. Certain non-resident aliens or members of a collective bargaining agreement may be excluded.

You might expect that the costs associated with establishing and maintaining a SEP-IRA would be minimal. They are. If you are looking to have your SEP-IRA contributions invested in a mutual fund, you should consider establishing a SEP-IRA with the fund, utilizing the fund's IRA trustee or custodian. Fees for this type of IRA will range from $5-$25 annually, exclusive of commissions. A similar rule might apply to investment products offered by a bank or insurance company.

Diversification

It won't take very long for SEP-IRAs to accumulate substantial assets that require investment diversification. And you may tire of maintaining what could develop into several different SEP-IRA accounts through different trustees and custodians. Sooner or later you will need to consider the advantages of a client-managed SEP-IRA, which will hold many different types of investments (stocks, bonds, mutual funds) all within one IRA account.

The client-managed account eliminates the need to transfer funds from one custodial account to another, with the associated paperwork and delays. Expect to encounter a first-year set-up of up to $25 and annual fees of $25 to $45. These fees are not unreasonable when you consider the simplicity and flexibility of the SEP-IRA account you have purchased. Don't forget that administrative fees are a deductible item when paid separately!

The accompanying chart details some of the major differences and similarities of a Simplified Employee Pension and Defined Contribution Keogh Plan.☐

See related comparative chart on next page.

Ms. Brown is vice president, Prescott, Ball & Turben, Inc., East Lansing.

PENSION/Continued	**Keogh Plan**	**SEP Plans**
What are the dollar and percentage contribution limits?	Lesser of 25% of earned income or $30,000 for money purchase or combined money purchase and profit-sharing plans. Lesser of 15% or $30,000 for profit-sharing plans.	Lesser of 15% or $30,000.
Must employees covered by a union bargaining agreement be included?	No.	No.
What are the age and service requirements for plan participation?	Age 25 (21 beginning in 1985) and up to 3 years of service. (1,000 hours defines year of service.)	Age 25 (21 beginning in 1985) and employed 3 of the last 5 years. Earned income of at least $200 in each of 3 years.
What is the required vesting schedule?	100% immediately if 3 years of service and age 25 eligibility. If 1 year and age 25, vesting could be as high as 10 years.	100% immediately.
Is ten-year-averaging for lump-sum distributors available?	Yes.	No.
Are loans available to plan participants?	To all but key employees.*	No.
Does a 10% penalty apply to distributions made prior to age 59½ (excepting death disability)?	Yes, if the plan is top-heavy** and the distribution is to a key employee. Does not apply to non-top-heavy plans.	Yes.
When must distribution commence?	Distribution must commence for all employees at the later of age 70½ or separation of service. Key employees must begin receiving distributions at age 70½ but they may remain employed and continue to fund their retirement plan.	70½.
Who may act as trustee?	In addition to a bank or financial institution, the employer or other qualified persons may be designated trustee.	Must be bank or other financial institution.
Are participants eligible to contribute to a regular IRA account?	Yes.	Yes.
May voluntary after-tax contributions be made to the plan?	Yes.	No.
When must the plan be established?	December 31.	April 15.
When must contributions be made?	April 15.	April 15.
What are the federal reporting requirements?	May have to file for a determination letter.	None.

* Key employee — Generally defined as a 5% or more owner

**Top-heavy — a plan in which the account values of key employees exceed 60% of the account values of all employees.

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class plans will be developed by BCBSM with consultation from "individual providers of that class or organizations representing the class." BCBSM may negotiate the plans with these provider organizations. However, it is not required to do so. The insurance commissioner is charged with establishing procedures whereby any person or subscriber could offer advice on the development, modification, and implementation of the plan. These plans will be submitted to the insurance commissioner and, if found acceptable, will be implemented for a period of two years. If at the end of the two years the insurance commissioner finds the plans were not adequate, the insurance commissioner has the authority to develop his or her own cost containment plans. The cost containment plans are required to provide the subscribers access to medical care and assure reasonable cost and quality.

Provider payout

PA 350 requires reimbursement arrangements that assure the rate of change in the total payment per member to each provider class is not higher than the compound rate of inflation and real economic growth. A formula for reimbursement and definitions of the economic terms used in determining the rate are clearly specified in the Act. This particular aspect of the bill could have a substantial impact on physician payouts as the rate of inflation in the last few years has receded.

MSMS currently is analyzing all the changes required under PA 350 and will seek alternatives to those portions which MSMS believes affect the quality of patient care delivered by physicians in Michigan.☐

By Sheri Greenhoe
Managing Editor

Order these brochures for your patients

Information on topics ranging from alternative delivery systems to professional liability is available to you from MSMS headquarters. The majority of these brochures, booklets and buttons, listed below, are available at no charge. To order, contact the Department of Communications, MSMS, 120 W. Saginaw, East Lansing 48823 (517) 337-1351.

Order these for yourself, doctor:

- Challenge of the 80s — a guide to successful medical practice (Cost: $5 members; $15.00 non-members)
- Alternative Delivery Systems
- Serving You (MSMS activities outlined)
- AMA Membership — What is it Worth?
- A New Reimbursement System
- CME Record Keeping Folder
- Map to MSMS headquarters
- Get Involved (for residents)
- Why You Should Become a Student Member of MSMS
- Michigan Legislative Directory
- Get on the Bandwagon (MDPAC and AMPAC)
- Maternal Health Desk Reference Cards

Order these for your patients:

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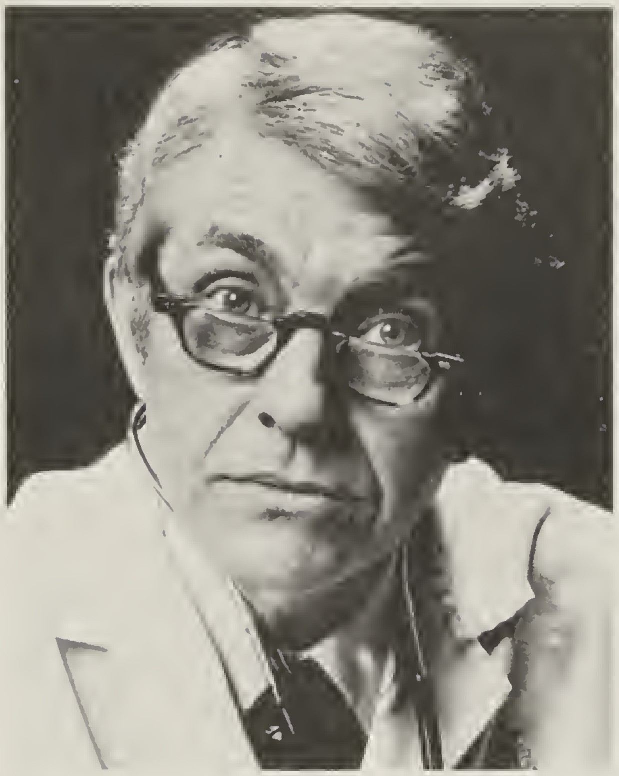
- Breast Cancer Treatments: A Helpful Guide for You
- If Someone in Your Family Wants to Become a Doctor
- If You and Your Doctor Have A Problem
- Buckle Up! Your Doctor Cares (buttons)
- AIDS Update



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Proposed legislation could hamper biomedical research

It is self-evident that biomedical research has been the basis for the many advances in patient care which are accepted as the standard in today's practice of medicine. The fact that it is self-evident may lead to some complacency on our part as we examine the wide assortment of issues which face our profession. The facts, however, should give us little cause for complacency. The future of biomedical research is now being called into question as our legislature considers two bills which have important bearing on this question.

Senate Bill 393 is one of two bills currently being considered that are backed by the Humane Society. If SB 393 is passed in its present form, it would eliminate the major source of dogs and cats necessary for biomedical research. The result could be significant, and in some cases a prohibitively expensive increase in the cost of biomedical research projects. That would lead to a loss of momentum in the development and introduction in scientific advances needed to solve some of our most critical health problems.

While the bill is aimed at the *source* of animals used in research, the real implication of this bill is to question the use of animals in biomedical

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Doctor Zuidema is professor of surgery and vice provost for medical affairs, University of Michigan.

By George D. Zuidema, MD

research. I would like to comment on the significance of this idea. The four leading causes of death in the US today include heart disease, cancer, stroke and trauma. These causes, collectively, account for perhaps 75 percent of all deaths. Without animal research, we would be unable to develop new operations for cancer victims, or patients with heart disease, strokes or trauma. We would be unable to develop new drugs for cancer patients, or those with infectious diseases, and we would be prevented from offering new surgical techniques to save trauma victims.

Some examples of specific developments which were derived from animal experimentation include: cardiac catherization; balloon angioplasty; the implantable fusion pump; organ transplants and vaccines against major epidemic diseases.

Biomedical challenges

Several challenges await the biomedical research community. We are just beginning to see increasing concern for a cure or prevention of AIDS. The treatment and prevention of cancer remain high on our priority list, as well as the belief that we can make major advances in treating neurologic and mental disorders. Thousands of infants might be saved if we knew more about the Sudden Infant Death Syndrome. If we are to continue to meet these challenges, the continued use of animals will be necessary for the foreseeable future.

The actual number of dogs and cats used in research must be put into perspective. Cats and dogs represent a small percentage of all the animals used in research. The majority used are rodents. However, those areas where the dog and cat model are deemed the best and most appropriate model are areas of critical concern to this nation's health and well-being.

Rather than restricting the use of animals in research, attention must be focused on ensuring that adequate safeguards are in place for animals to be treated properly and for research projects to be appropriately designed. This is achieved in several ways: to the extent that research is externally sponsored by agencies such as the National Institutes of Health, there is very stiff competition for funding and a rigorous peer review process is used to ascertain that each research project has scientific merit and is not redundant or outdated.

Other factors

Several other factors play a role in ensuring the proper use of animals:

- State and federal laws require regular inspection by state and federal auditors; the NIH has recently updated its guidelines on the use of animals in research;
- Many research universities have established units for laboratory animal medicine as a separate academic unit;
- The establishment of committees (including external members) on the use and care of animals to provide oversight for research projects;
- Development of a university-wide policy on the use of animals, approved at the highest level of the institution.

A nationwide task force responsible for developing guidelines for research institutions on the use of animals in research has recently published the *National Research Council Guide for the Care and Use of Laboratory Animals*. This publication is the standard accepted by US research institutions.

Senate Bill 393 has serious implications for us in terms of performing the medical research that the people of this state expect. We believe that the use of animal models in medical research plays a vital role in addressing the items on our national health agenda. The cost in human terms is hard to describe, and it is important that we recognize both the scope and the urgency of the problem.☐

By Herbert A. Aue

Bertha VanHoosen, MD was a woman of many "firsts"

"Presented in honored memory of Bertha Van Hoosen, MD, whose historic contributions to both state and society have been recognized by her election to the Michigan Women's Hall of Fame."

That is the wording on a handsome plaque presented earlier this year by the Michigan Women's Hall of Fame, based in Lansing.

Doctor Van Hoosen deserves recognition in this issue of *Michigan Medicine* and also by the Hall of Fame because . . .

- She was born near Rochester in Oakland County in 1863;
- She was graduated from the University of Michigan Medical School in 1888;
- She did an intership at Detroit Woman's Hospital, now Hutzel Hospital;
- She was employed as a staff physician at the State Mental Hospital in Kalamazoo;
- She had an outstanding career in medicine from 1888 to 1950 serving chiefly in Chicago, but also in Boston, St. Louis and Michigan;
- She was one of the founders of the LaLeche League;
- She was the first president of the American Women's Medical Association and worked tirelessly for the recognition of women in medicine;
- She was included in *Who's Who;*
- She was an honorary member of the International Association of Medical Women, a recognition shared then only with Mme. Marie Curie of France;
- Her death was recognized in *Time Magazine.*

A distinguished physician

Doctor Van Hoosen is credited with bringing about the "acceptance of women in the medical field both in this country and abroad," commented the *Rochester Clarion* in 1952 after her death.

The tribute to Doctor Van Hoosen at the 1985 Awards Dinner of the Michigan Women's Hall of Fame was presented by Marjorie Peebles-Meyers, MD, of Detroit. Doctor Peebles-Meyers herself is a distinguished Michigan physician — a recipient of the "Michigan Outstanding Doctor of the Year Award" and the first woman member of the MSMS delegation to the deliberations of the American Medical Association House of Delegates.

At the Awards Dinner, the plaque honoring Doctor Van Hoosen was accepted by Clara Raven, MD, Detroit, who trained in Chicago and was one of the young women physicians "adopted" by Doctor Van Hoosen. The plaque now is displayed in the Avon Township Museum.

Michigan upbringing

Bertha was born in Stoney Creek in 1863 near Rochester on the family homestead where her grandparents came in 1823 using the Erie Canal "a cent and a half a mile and a half an hour a mile."

She was graduated from Pontiac High School when she was 16 and entered the U-M Literary Department to take premedic courses. She received her AB degree and taught physiology and calesthenics in

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Mr. Auer was editor of *Michigan Medicine* for many years and now resides in Traverse City.

St. Louis for a year.

In the fall of 1885 she presented her credentials to the U-M Medical School and she was accepted without any entry examinations. While taking classes, she was a demonstrator of anatomy — for a salary of $50 a month. She received her medical degree in 1888. She did an internship at Women's Hospital (Hutzel) in Detroit and became very concerned about the problems of illegitimate offspring. She later expanded that interest in Boston and Chicago.

She joined the Kalamazoo State Hospital as a staff physician for $75 a month in charge of special care of insane women patients.

Doctor Van Hoosen was the only woman on the staff of eight physicians. The men decided she should be the hospital dentist and she wrote of this incident in her book *Petticoat Surgeon*: "One day as a nurse attendant stooped to button the collar of an untidy patient, the patient lowered her head and with a single clamp of the jaw bit off the end of the attendant's index finger. The following day all the patient's front teeth were extracted."

She recalled in *Petticoat Surgeon* that she "examined new female patients in Kalamazoo for evidence of any physical injury such as cuts, scars, burns or breaks but made no further examination. I never made a note on the mental or physical conditions of any patient . . . The hospital superintendent taught me to write families of patients and use phrases that could not be used in court against the hospital or staff. I became an expert in expressing myself in such terms as 'if your sister continues in her present condition, I see no reason why your anxiety concerning her should be more than you naturally feel.'"

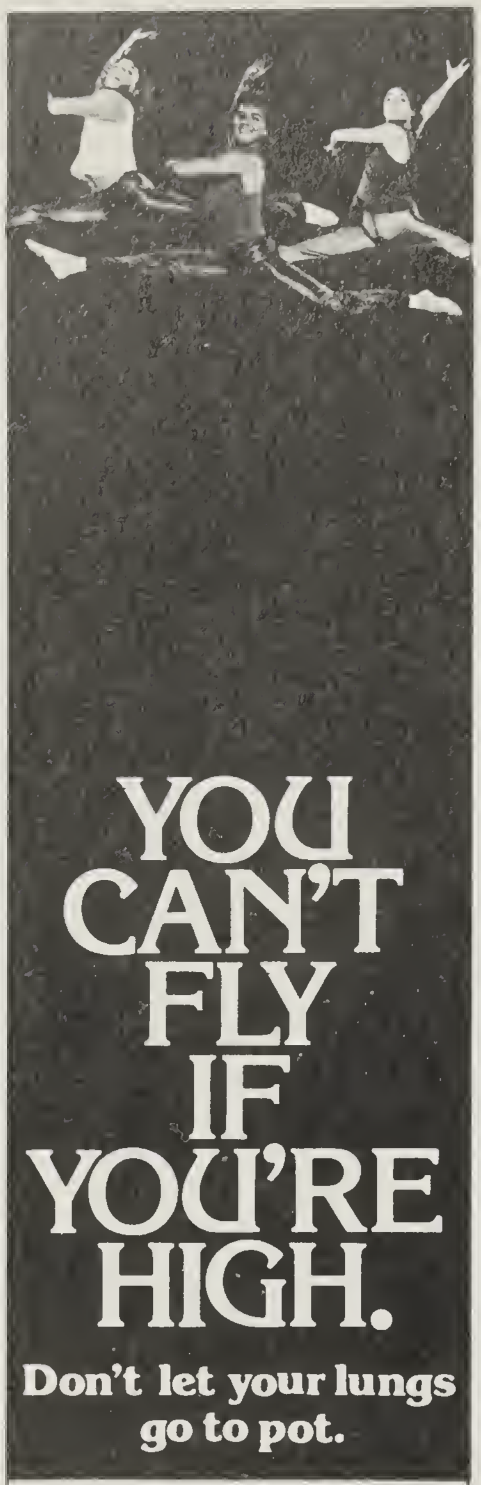
At the mental hospital, she wrote, "treatment of the insane was little more than confinement, a regular routine of living, employment, amusement, and occasional doses of castor oil and iron tonic." Physiotherapy, shock treatment, psychoanalysis were all later developments.

On to Chicago

After 18 months in Kalamazoo, she went to the New England Hospital for Women and Children in Boston and then into private practice in Chicago, where she rented her first office for $30 a month. Soon after her arrival in Chicago she served as an emergency physician at the Columbian World's Fair — at $10 a day — and that helped spur her practice.

During her years in Chicago in addition to private pratice, she served at various times as professor of clinical gynecology at the College of Physi-

Continued on next page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cians and Surgeons (University of Illinois College of Medicine) as the first woman at Cook County Hospital, as professor at Women's Medical College at Norhwestern, and as head of obstetrics at Loyola University School of Medicine. She received an LLD degree from Loyola in 1929.

After 18 years of practice in Chicago, she took her first vacation and went to Budapest in 1900 to read a paper at the International Medical Congress on "The Effects of Scopolamine Morphine Anesthesia in the Fetus in Utero." She later visited, conferred and spoke at many famous European hospitals and in the Orient. She was in much demand as a speaker.

AMWA co-founder

Doctor Van Hoosen is recognized as a co-founder of the American Woman's Medical Association. The AMA admitted its first woman member in 1871 and Doctor Van Hoosen attended her first meeting in 1904. Four years later she helped the AMA begin a tradition of annual dinners for women doctors. In 1915, in connection with the 50th anniversary of the Women and Children's Hospital in Chicago she invited a group of women doctors to meet at the Chicago Woman's Club. The AMWA took early form at that event and she was elected the first president in 1917.

In Chicago, she was one of the first doctors to advocate sex education in the schools — far ahead of recent and current trends. Early in the 1920s she was a member of the Chicago Woman's Club Committee on Social Purity and lectured on sex in the Chicago Public Library and other locations "to audiences of mothers and children, club women and working girls." In 1912, the Chicago school superintendent asked Doctor Van Hoosen to select medical men and women to talk to students. She also lectured frequently about the health dangers of smoking and drinking.

She wrote a book about twilight sleep based on many experiences she had in her own six-bed hospital in Chicago because she wanted to use that new and somewhat untried anesthetic to aid in births. She also advocated breast feeding as a health measure for infants.

In reports about her accomplishments she often is cited for her national reputation for her procedures and techniques in appendix and hemorrhoid operations.

In addition to her accomplishments in the practice of medicine, she worked to help convince the Army and Navy to commission women doctors. The Sparkman Bill was signed into law in 1942 by President Roosevelt after 25 years of effort by Doctor Van Hoosen and many others.

Her niece, Sarah Van Hoosen was very prominent as an expert farmer and civic leader. She served on the governing board for Michigan State University where a dormitory bears her name. Bertha took great pride in her niece Sarah and once said, "Being 'father' to Sarah gave my life a supreme motive."

Doctor Van Hoosen retired from her Chicago practice when she was 80 years old and returned to her Avon Township home. She continued to see patients and gave a physical examination for an old friend on October 30, 1951. That night she suffered a severe stroke, then spent three months in a Mt. Clemens hospital and died June 7, 1952 in a nursing home in Romeo.

This dedicated physician, now honored further by the Michigan Women's Hall of Fame, certainly practiced as she preached to younger physicians: "No profession demands more attention to detail and consumes more time than medicine."☐

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Reye's Syndrome update

To date, there have been no Michigan cases of Reye's Syndrome reported during the 1985-1986 reporting season which began on October 1, 1985.

During this same period, there was a single case reported from Ontario in November, a single case from Minnesota in December, and a single case from Ohio and from Wisconsin in January. Indiana reported no cases for this period.

In Michigan, influenza B has been isolated from Washtenaw, Ingham, Kalamazoo and Houghton Counties. There have been seroconversions to influenza B from Detroit, Ottawa and Leelanau Counties. Influenza A (H3N2) has been isolated from Saginaw County and there was a seroconversion to influenza A from Ingham County. Nine counties have had school closings due to influenza-like illness and nine other counties have reported high absenteeism in schools caused by influenza-like illness. High rates of influenza-like illness have been reported from nursing homes in Ingham, Saginaw and Oakland Counties.

Subjects needed for menopause studies

Healthy women between the ages of 45-60 who have not entered menopause are being sought for two research projects at the Lafayette Clinic in Detroit.

Women volunteers must be experiencing a regular menstrual cycle and have none of the symptoms associated with onset of menopause. They must be in good general health and free of drugs for the course of the study.

All volunteers accepted for the research will receive a free physical examination and cash compensation.

Researchers Leonard Germaine, PhD, and Robert Freedman, PhD, are attempting to gain an understanding of the menopausal symptoms of hot flashes and perfect a behavioral analog to pharmaceutical treatment of the condition.

In a related study, the researchers are cooperating with Abbott Laboratories to determine the lowest effective dose of an estrogen treatment for symptoms of menopause. (High levels of estrogen, a standard treatment for the disorder, have been associated with increased risk of cancer among women beyond menopausal years.)

For information about participation in the studies, call Doctor Germaine at the Lafayette Clinic between 9 am and 4 pm (313)256-9521.

Institute to study substance abuse

The Addiction Research Institute of Michigan was formed in April to study problems related to drug and alcohol abuse. Currently moving into its new headquarters on Wayne State University's medical campus, the Institute is the only organization of its kind in the state and was founded with the cooperation of Wayne State University, The Michigan Office of Substance Abuse Services and the Detroit Health Department.

Over the next five years researchers hope to build the Institute into a nationally-recognized, multidisciplinary center for addiction studies.

The Institute will study policy, prevention and treatment. Policy deals with environmental factors that control use of mood- and mind-altering substances such as the recent liquor tax increase and its effect on liquor use.

On the prevention side, a pilot study focusing on early elementary school education is underway. The program being evaluated builds kids' self-esteem and their resistance to peer pressure regarding the abuse of alcohol or drugs as they get older. With the Bureau of Substance Abuse Services of the Detroit Health Department, the Institute will provide a service and research program in the city.

For further information contact the Addiction Research Institute, 1368 Scott Hall, 540 E. Canfield Ave., Detroit 48201 (313) 577-1388.

Beaumont hospital laser study

The American Medical Association announced recently the results of a study that provides the first clear-cut evidence of the laser's value in combatting diabetic macular edema.

In diabetic macular edema, excess fluid swells retinal tissue, blurring vision. This visual impairment can have a drastic effect on the quality of life for the person whose visual acuity has declined enough to prohibit reading, driving a car or performing adequately on the job. An estimated five percent of the nation's 10 million diabetics have macular edema and may be at risk of losing their vision because of this condition.

William Beaumont Hospital is one of 23 medical centers participating in the still ongoing study supported by the National Eye Institute. The National Eye Institute is a component of the federal government's National Institutes of Health. For further information on this nationwide study, contact Valerie Mahaczek at William Beaumont Hospital (313) 288-8425.

Continued on page 124

HYPERTENSION

A One-Day Symposium

This symposium will cover a variety of topics including:

- Is Stepped Care Therapy for Hypertension Appropriate in the 1980s?
- Pathogenesis of Hypertension
- Renovascular Hypertension
- Management of Patients with Treatment-Resistant Hypertension
- Geriatric Hypertension
- New Developments in Anti-hypertensive Therapy
- Non-pharmacologic Management of Hypertension
- Hypertension in Pregnancy

The distinguished speakers will be:
Edward D. Frolich, MD, Vice President, Education and Research - Alton Ochsner Medical Foundation; New Orleans, Louisiana
James C. Stanley, MD, Professor of Surgery; Head, Division of Peripheral Vascular Surgery - The University of Michigan Medical School; Ann Arbor, Michigan
Ray W. Gifford, Jr., MD, Vice Chairman, Division of Medicine - Cleveland Clinic Foundation; Cleveland, Ohio
James R. Sowers, MD, Chief, Endocrine and Hypertension Division; Professor, Internal Medicine and Physiology - Wayne State University; Detroit, Michigan
Stevo Julius, MD, Professor of Internal Medicine and Physiology; Director, Division of Hypertension - University of Michigan; Ann Arbor, Michigan
Frank A. Finnerty, Jr., MD, Professor of Medicine - Georgetown University (retired); Washington, D.C.
David R. Rovner, MD, Professor of Medicine; Chief, Section of Endocrinology and Metabolism - Michigan State University; East Lansing, Michigan
J. Alan Herd, MD, Professor of Medicine - Baylor College of Medicine; Medical Director - Institute of Preventive Medicine of the Methodist Hospital; Houston, Texas

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Polio Network formed

Polio has resurfaced to strike thousands of Michiganians who thought they had conquered the dread disease decades ago. Today polio survivors are struggling to understand and deal with an unexpected second strike from their old nemesis.

"We've turned to "networking," said Charlene Bozarth, chairperson of Michigan's newly-formed Polio Network. "Twenty-five percent to 70 percent of the half million polio survivors nationwide can expect to face unaccustomed fatigue, muscle weakness and pain, the longterm side effects of polio. After undergoing one rehabilitation 30 to 40 years ago, a lot of us are having a rough time dealing with these new problems."

"Most of us have no idea what's happening because the medical community is, by and large, either unaware of our problem or refuses to recognize it. So, we've formed the Polio Network to: (1) reach polio survivors who don't know why they have suddenly become weak and pain-wracked, and to give them support; (2) provide mutual support among ourselves in terms of physical and psychological rehabilitation; (3) spur the medical community into serious research of the causes and rehabilitation potential of our problem, and (4) make the general public aware of our plight and of the need for programs to help those of us who suddenly find ourselves unable to function normally."

Ms. Bozarth says her group's primary goal is to inform Michigan's 10-15,000 polio survivors about these delayed effects and offer a helping hand. For further information, polio survivors should contact Polio Network, PO Box 14148, Lansing 48901-4148, or call (toll free) 1-800-292-2729.

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Temporary pacemaker pill

University of Michigan researchers have developed a pill pacemaker, a new nonsurgical technique for temporarily pacing the heart to help diagnose cardiac illness and stabilize abnormally fast heartbeats.

The technique avoids the time, cost, risk and discomfort of inching a catheter electrode through a patient's vein to the heart—a surgical method of pacing that requires hospitalization.

Instead, an electrode is placed inside a gelatin capsule the size of a cold pill. A fine thread of insulated wire is attached to the capsule. The patient swallows the capsule and the thread remains in the throat, the researchers said.

The physician reels in the thread until the thread reaches a point in the throat closest to the left atrium. From this position, the heart can be stimulated with the pill electrode, usually for less than 30 minutes. It is not designed for long-term heart pacing.

The pill device can help evaluate patients with coronary artery disease because their heartbeats must be accelerated before being analyzed, said Professor Janice Jenkins of U-M's Department of Electrical Engineering and Computer Science.

Traditionally, patients have been placed on a treadmill or subjectd to some other exercise to elevate their pulse. Transesophageal atrial pacing allows complete control of the heart rate independent of patient performance and can be used in patients who are physically unable to achieve intense levels of exercise.

The precise heart control proided by the pill electrode and its ability to accelerate the pulse without moving the patient combine to help produce crisper images of the heart using such devices as X-ray or nuclear cameras, which rely on the heartbeat to trigger their exposures, Jenkins said.

The pill electrode also can be used to stabilize abnormally elevated heartbeats through overrive pacing, a method of correcting atrial flutter and other abnormally fast heartbeats by accelerating the heart electrically, then slowing the rate. In many cases, a normal heart rhythm will result.

"Transesophageal overdrive pacing offers several advantages; the technique offers virtually universal noninvasive access to the atrium; it can be performed in an outpatient setting; it requires minimal or no sedation; and there is little discomfort," Jenkins said.

The pill pacemeker also serves as a comfortable alternative to an electrode catheter inserted through the nasal

Continued on page 126

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cavity and into the throat, another method of transesophageal atrial pacing.

Head trauma treatment center

Jewish Vocational Service and Community Workshop (JVS-CW), in partnership with Sinai Hospital, have opened the Center for Comprehensive Rehabilitation (CCR), a day treatment program for people who have suffered closed head injuries. Head trauma is the leading cause of death in the United States for people under the age of 34. Nationally, 50,000 people per year suffer brain injuries, usually as a result of a drug or alcohol related automobile or motorcycle accident. Survivors, mostly 15- to 25-year-old-males, are often left with serious intellectual or emotional impairments. They require intensive rehabilitation services to relearn basic cognitive skills.

The Center's goal is to help the injured individual reenter the community, to return to school or to work. Family support is vital to the success of this goal and family members are included in all aspects of the CCR program.

The rehabilitation team works together to help clients adjust to the effects of brain trauma and achieve their potential for independence and a productive lifestyle. Individualized therapies are provided at the Center in Oak Park, or, as needed, in the individual's home environment. The Center offers full and half day programs, five days per week.

The Center for Comprehensive Rehabilitation is located at 25900 Greenfield Road, Suite 254, Oak Park 48237. For more information, call Barbara Feldman, (313) 968-8889, 8:30 am—4:30 pm.

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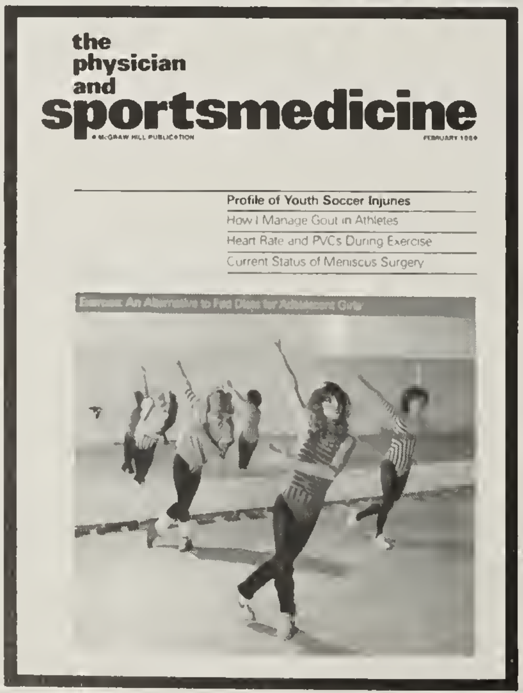
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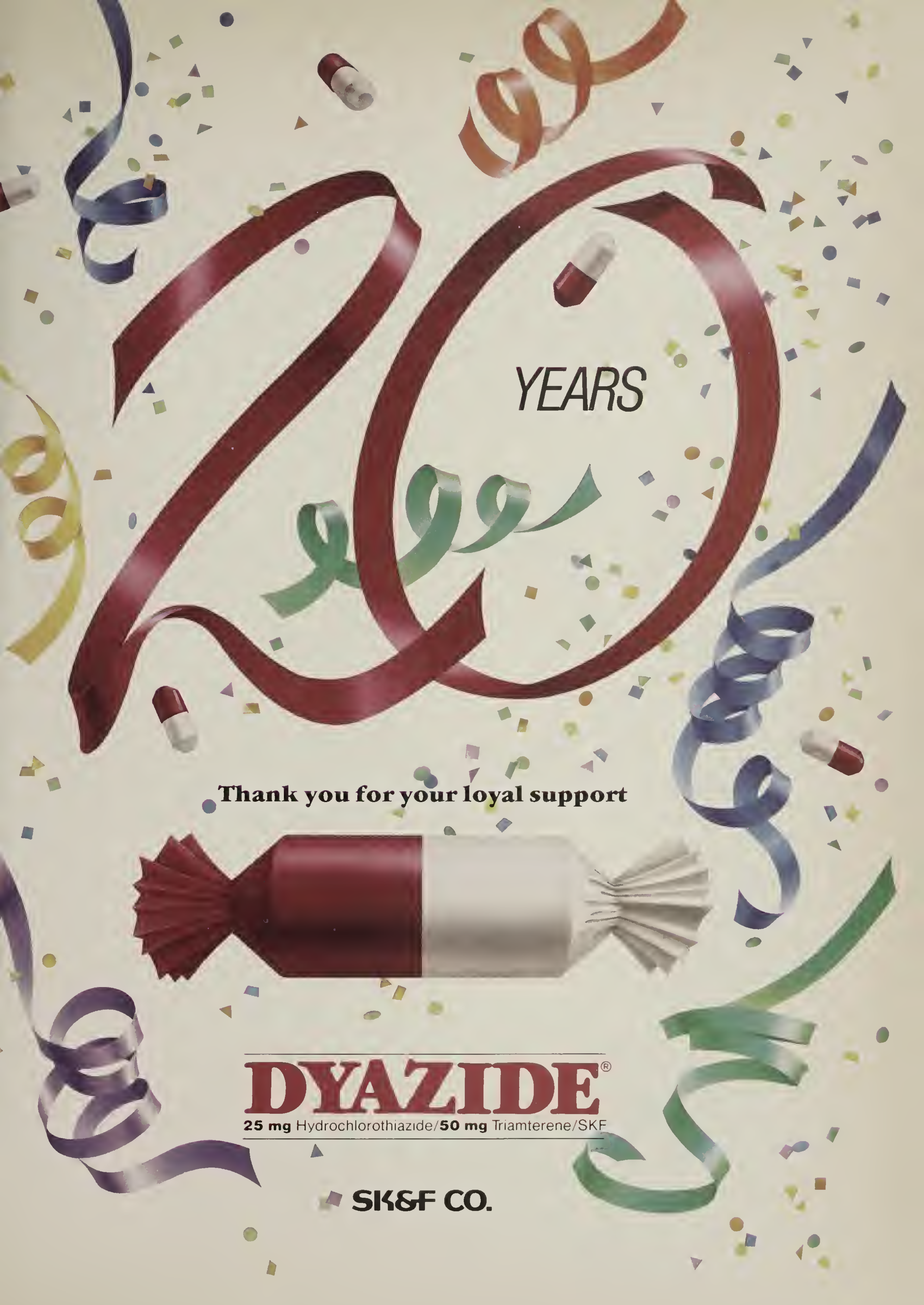

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J-6138 January 19

House Speaker Owen visits MSMS

Although the legislature and MSMS haven't always seen eye-to-eye on the subject of liability tort reform, MSMS Board Chairman Carl A. Gagliardi, MD, left, and House Speaker Gary Owen (D-Ypsilanti) shared a light moment during a recent Board of Directors meeting in East Lansing.

These are the final days of legislative effort to hammer out a liability tort reform package. Members are urged to contact lawmakers amd write letters to the editors of hometown newspapers. Emphasize the need for limits on noneconomic awards, a stricter statute of limitations, a tougher collateral source rule and structured payment of awards. Address your letters to legislators to State Capitol Building, Lansing 48909.

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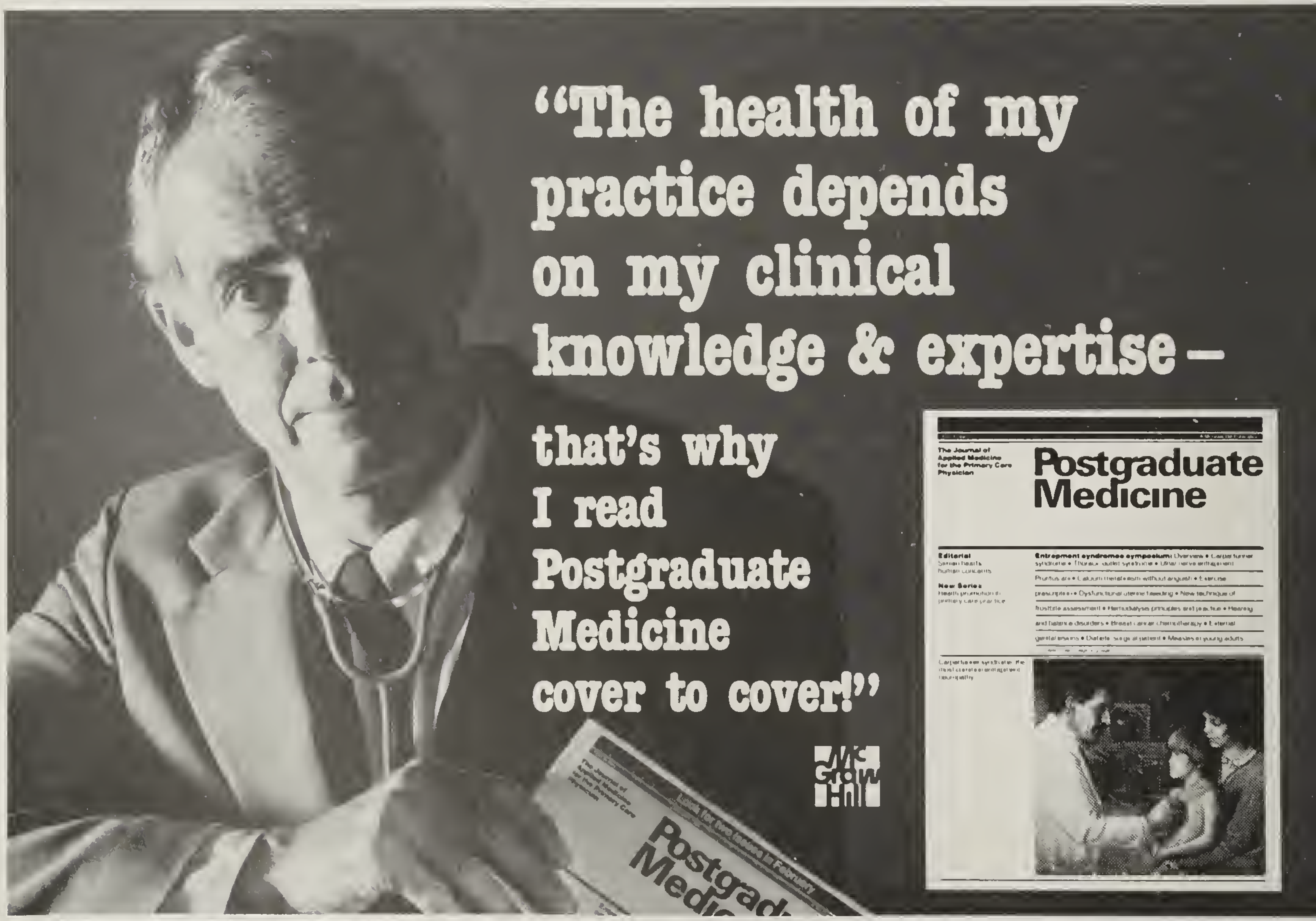
USING A PATIENT SURVEY?

Have you developed or found a form for obtaining feedback from your patients? If you have, please share it with MSMS. The Public Relations Subcommittee of the Advisory Committee on Communications and Professional Relations wishes to review the forms that are in use, then develop a new one containing the *best* features from *your* samples.

Your comments about your patient survey form are welcome, too. Tell us what you like best, or least, about your version, and what you would do differently. Explain how you distribute forms, and how you evaluate the results.

Please send your sample forms and comments, anonymously if you wish, to Sheri Greenhoe, MSMS, 120 W. Saginaw, East Lansing 48823.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1

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Leadership in Tort Reform

MPMLC officers and executives have worked with state officials for new laws to control the cost of medical liability insurance. We have provided legislators vital information and testimony to support the passage of beneficial legislation. MPMLC has played an important role in organized medicine's effort to enact tort reform in Michigan.

Leadership in Loss Prevention

Services to help physicians reduce the chances of liability claims are among the benefits that MPMLC provides policyholders. MPMLC is offering its Malpractice Awareness Program (MAP) workshops for the second year to assist physicians identify risks and ways to avoid them. The company's MAP sessions provide doctors vital information based on confidential analyses of closed claims. Loss prevention is gaining recognition as an effective strategy to reduce the costs of medical liability insurance.

Watch for new MPMLC programs to assist policyholders minimize risks in the practice of medicine.

Arbitration Can Help

You can increase the chances of resolving claims more quickly and less expensively by having patients sign arbitration agreements. Research shows that arbitrating medical liability claims may reduce costs and expedite settlements. Now patient treatments in the office for one year are covered by IBA 100, the form approved by the insurance commissioner. Additional forms cover various types of medical care provided in hospitals, HMOs and other milieus. Call the American Arbitration Association toll-free, 800-482-0660, for further information about Michigan's Medical Arbitration Act.

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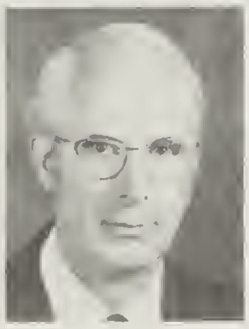
PHYSICIANS IN THE NEWS

Dean


Eyler

Jenkins

Mouw

Overy

Papp

John H. McLaughlin, MD, of Birmingham recently was installed as the president of the Oakland County Medical Society. . . . The Board of Governors of the American Institute of Ultrasound in Medicine has elected **Michael A. Wainstock, MD,** Detroit, a fellow in their academy. This award is given only by invitation and unanimous vote to those who have done outstanding research, education, and lecture in the field of ultrasound. . . . **William R. Eyler, MD,** Detroit, was awarded a 1985 gold medal by the American College of Radiology. This is the most prestigious award given by the association and recognizes outstanding achievements in radiology. . . . **George A. Dean, MD,** Southfield, was selected as the 1985 Family Physician of the Year by the Michigan Academy of Family Physicians. . . . The Kent County Medical Society at its annual meeting elected **Albert R. Dugan, MD,** president. **Willard S. Stawski, MD,** is the retiring president of the Board. **Peter D. Van Vliet, MD,** was elected president-elect and **W. Patrick Mazier, MD,** was elected director. Continuing as directors are **Peter B. App, MD, Charles R. Henry, MD,** and **James M. Riekse, MD.** . . . **Dirk Mouw, MD,** is the recipient of the West Central Michigan Hospital Council's 1985 Distinguished Service in Health Care Award. The award was given for his outstanding record of personal dedication to his patients, community and profession. . . . Detroit Receiving Hospital and University Health Center elected **Barbara J. Jenkins, MD,** president of the medical staff. She is the first woman at DRH-URC to be elected to this office. . . . **James H. Graves, MD,** recently assumed responsibilities as director of the Oakland County Community Mental Health Services Board. He is former director of Wayne County mental health programs. . . . The American Heart Association of Michigan has named **Donald C. Overy, MD,** Pontiac, an Honorary Life Board Member. This honor has been given only five times in the history of AHA in Michigan. . . . **Steven Werns, MD,** Ann Arbor, one of six finalists, presented a paper in the American College of Cardiology Young Investigator of the Year competition in Bethesda, Maryland on March 10. . . . The Arthritis Foundation presented the 1985 Lee C. Howley, Sr., Prize for Research in Arthritis to **C. William Castor, MD,** of the University of Michigan Medical School. The $10,000 award is the major US award for arthritis research . . . **Douglas A. Sargent, MD, JD,** Director of the Neuroscience Consultation Group, and Trustee of the American Psychiatric Associaton will be on the conference faculty of the AMA 7th National Conference on the Impaired Physician. . . . **Donald J. Aiken, MD,** was honored recently for his election as president of the Ingham County Medical Society. **Paul C. Linnell, MD,** past president and **Clyde R. Flory, MD,** president-elect also were present for this special evening. . . . **John P. Papp, MD,** gastroenterologist at Blodgett Memorial Medical Center, Grand Rapids, is the new president of the American College of Gastroenterology.☐

Correction

The editors regret having identified Charles M. Bell, MD, 1042 Cambridge Drive, SE, Grand Rapids, as "the late" Charles M. Bell, MD. The error occurred in an article on the history of the Michigan Conference on Maternal and Perinatal Health, in the January issue of *Michigan Medicine.*

Do you know this physician?

MSMS has been unable to reach Stanley M. Lynk, MD, formerly of Davison. If you have any information about Doctor Lynk, please contact Peg Berry at MSMS headquarters so that she may update membership files.□

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March 19-20 — MSMS Maternal Health Conference, "25 Years of Growth and Change," Hyatt Regency Dearborn, contact: Sherry Fent, MSMS headquarters (517) 337-1351.

March 19 — MSMS Board of Directors Meeting, MSMS headquarters, East Lansing, contact: William Madigan (517)337-1351.

March 26 — MSMS Practice Management Seminar: Advanced Marketing, Kinsley Inn, Bloomfield Hills, contact: Donna Farougi, MSMS headquarters (517)337-1351.

April 9 — MSMS Practice Management Seminar: Medical Practice Collection Management, Hyatt Regency, Dearborn, contact: Donna Farougi, MSMS headquarters (517)337-1351.

April 11-13 — AMA's Seventh National Conference on the Im-

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April 17-18 — MSMS co-sponsored program on The Child with Chronic Illness/Disability: A Framework for the Future, East Lansing, contact: Mary Helfer, (517)353-8856.

April 23 — MSMS Practice Management Seminar: Medical Practice Collection, Marriott Inn, Grand Rapids, contact: Donna Farougi, MSMS headquarters (517)337-1351.

April 30 — MSMS Practice Management Seminar: Advanced Marketing, Marriott Inn, Grand Rapids, contact: Donna Farougi, MSMS headquarters (517)337-1351.

May 2-3 — MSMS House of Delegates, Hyatt Regency Dearborn, contact: Richard Campau (517)337-1351.

May 12-14 — MSMS/Auxiliary Annual Session, Grand Traverse Resort, Traverse City, contact: Viola M. Heins, MSMS headquarters (517)337-1351.

May 15 — MSMS Sports Medicine Conference, Clarion Convention Center, Lansing, contact: Sherry Fent, MSMS headquarters (517)337-1351.

May 28 — MSMS Hospital Medical Staff Section Leadership Conference, Novi Hilton, contact: Thomas White, MSMS headquarters (517)337-1351.

June 15-18 — AMA Auxiliary Annual Session, Drake Hotel, Chicago, contact: Viola M. Heins, MSMS headquarters (517)337-1351.

June 27 — Practice Management Seminar: Computers in the Medical Practice, Hilton Shanty Creek, Bellaire, contact: Donna Farougi, MSMS headquarters (517)337-1351.

July 17-20 — MSMS Midsummer Board meeting, St. Clair Inn, St. Clair, contact: William Madigan (517)337-1351.

August 22 — Practice Management Seminar: Computers in the Medical Practice, Boyne Mountain, Boyne Falls, contact: Donna Farougi, MSMS headquarters (517)337-1351.

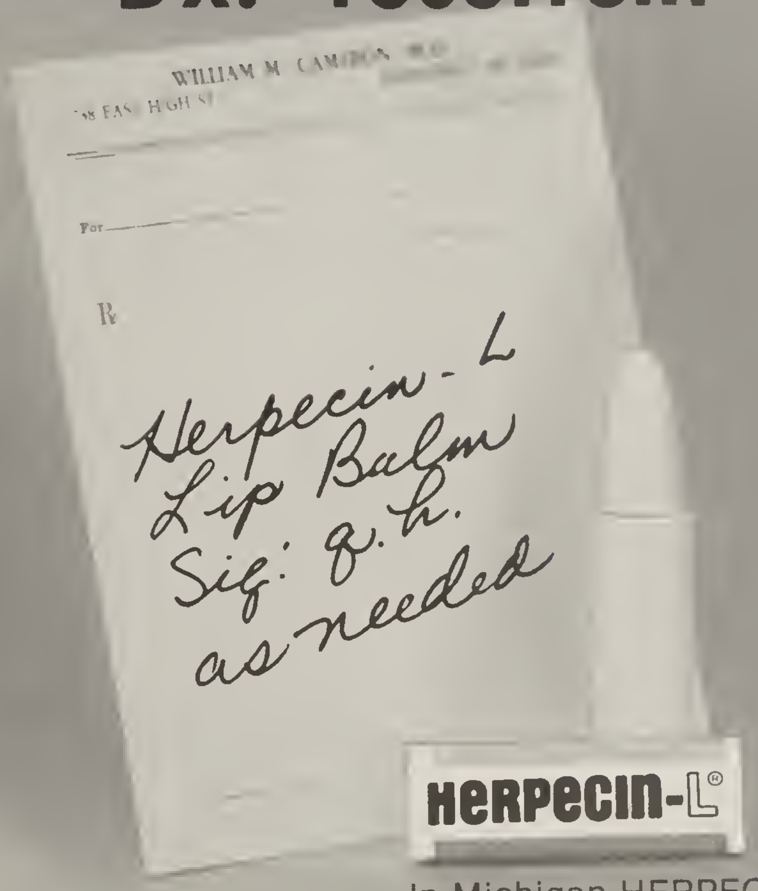
OTHER MEETINGS

March 19-22 — 1986 Great Lakes Athletic Trainers Association Winter Meeting and Sports Medicine Symposium, Amway Grand Plaza Hotel, Grand Rapids, contact: Lee Kermode, 2317 Gleneagle Drive, Kalamazoo 49001.

May 1-2 — Michigan Chapter, American College of Surgeons, Coller Day Competition, Omni International Hotel, Detroit, contact: Viola M. Heins, MSMS headquarters (517)337-1351.

May 17-18 — Michigan Society of Pathologists Immunopathy and Fine Needle Aspiration Lesions, St. Clair Inn, contact: Viola M. Heins, MSMS headquarters (517) 337-1351.

Dx: recurrent herpes labialis



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Centerville
Doctor Bushong died November 22 at the age of 83. He graduated in 1931 from the University of Cincinnati Medical School. He had been affiliated with Thirlby Clinic in family practice and internal medicine.

John J. Connors, MD
Franklin
Doctor Connors died November 26 at the age of 84. He graduated from the Creighton University Medical School in 1927. Doctor Connors had been affiliated with Mt. Carmel Mercy Hospital since 1937.

Reed O. Dingman, MD
Ann Arbor
Doctor Dingman died December 24 at the age of 79. He graduated from the University of Michigan Medical School in 1936 and completed his residency in plastic surgery in 1946 at Blodgett Memorial Hospital. Doctor Dingman was former president of the American Society of Plastic and Reconstructive Surgeons.

Elisha S. Gurdjian, MD
Bloomfield Hills
Doctor Gurdjian died November 30 at the age of 85. He graduated from the University of Michigan Medical School in 1926. Doctor Gurdjian was the third practicing neurosurgeon in Detroit and the first chief of neurosurgery at Grace Hospital.

James M. LaBerge, MD
Hillsboro Beach, FL
Doctor LaBerge died December 10 at the age of 78. He graduated from the University of Michigan Medical School in 1934. Doctor LaBerge specialized in the treatment of eyes, ears, nose and throat.

Kenneth H. Lowe, MD
Battle Creek
Doctor Lowe died November 29 at the age of 82. He graduated from the University of Michigan Medical School in 1931 and established a private otolaryngology practice in 1934. Doctor Lowe retired in 1970.

James C. Moloney, MD
Tucson, AZ
Doctor Moloney, formerly of Oakland County, died November 8 at the age of 85. Doctor Moloney graduated from Georgetown University Medical School in 1924 and specialized in neurology and psychiatry.

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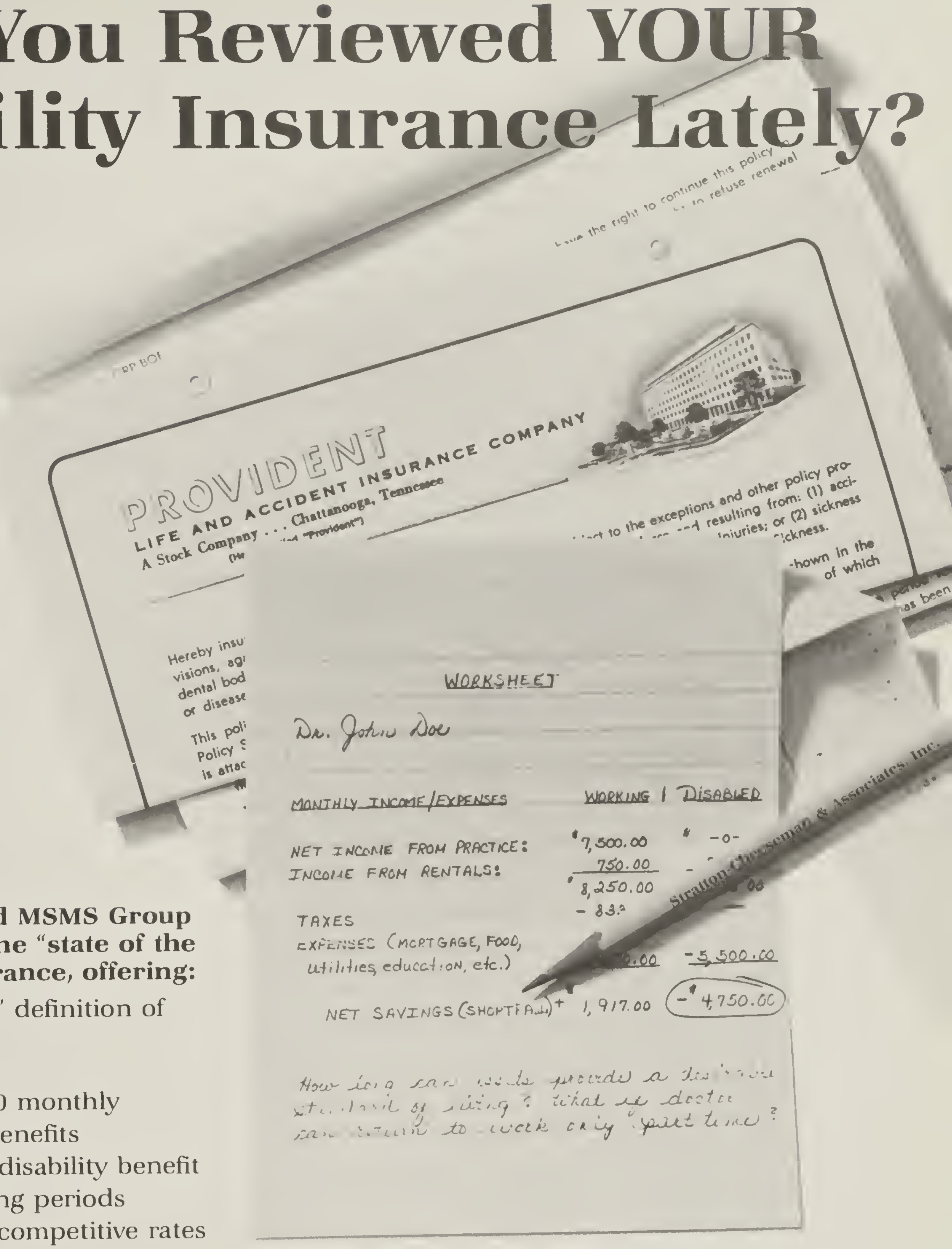
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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

D. A. Axelrod, MD — RHU/IM
36300 Van Dyke
Sterling Heights 48077

J. W. T. Ayers, MD — OBG
1405 E. Ann Street
Ann Arbor 48104

Richard Balon, MD — P
23760 Carriage Hill Rd. #802
Southfield 48075

Michael W. Beasley, MD — GP
1022 Crapo Lake Trail
West Branch 48661

John E. Brewer, MD — FP
5240 Van Atta Road
Okemos 48864

R. L. Christensen, MD — FP
1470 Peck Street
Muskegon 49441

William J. Chung, MD — PD
455 S. Livernois C-22
Rochester 48063

A. V. de Leon, Jr., MD —
IM/PUL
133 S. Gratiot, Ste. C
Mt. Clemens 48043

T. C. DelaCruz, Jr., MD — NS
2406 Lake Lansing Road
Lansing, MI 48912

Jonathon H. Epstein, MD — IM
13324 North Blvd.
Vicksburg 49097

W. A. Fishbeck, MD — OM/FP
1411 Pheasant Ridge
Midland 48640

Alan M. Gardner, MD — GP/EM
4565 Halbert Road
Battle Creek 49017

R. D. Hobbs, MD — IM/NEP
47 E. Chicago
Quincy 49082

F. P. Hoenke, MD — FP
610 Caring Street
Hillman 49746

Richard Jankowski, MD — DR
4304 Woodlawn
Midland 48640

Marlen F. Junck, MD — DR/NM
265 Greenwood
Holland 49423

Marius S. Juzych, MD — OPH
17800 E. Eight Mile Road
Harper Woods 48225

Basem Kayali, MD — IM/CD
26755 Ballard
Mt. Clemens 48045

G. A. Kuldanek, MD — IM
1840 Wealthy Street, SE
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Lenard W. LaBelle, MD — ORS
4254 Oak Forest Ct., SE H-5
Grand Rapids 49506

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Peter A. Newhouse, MD — FP
325 E. Centre
Portage 49081

Elmer L. Novis, MD — GP/GS
3216 Stone Street, #3
Port Huron 48060

L. Donald Pipe, MD — R
184 Criag Lake
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302 W. Chestnut
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Steven M. Rapp, MD — NS
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Bloomfield Hills 48013

David G. Reed, MD — FP
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Inder J. Saini, MD — PD
3793 Barbara Drive
Sterling Heights 48077

Julia E. Spalding, MD — FP
251 Clarendon
East Lansing 48823

T. Sreecharana, MD — GS
435 Frost Drive, North
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Pongchayut Surapipith — GS
1071 Professional Drive Bldg. 4
Flint 48504

D. Mark Upham, MD — GP
Alpena General Hospital
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David J. Veeneman, MD — PD
1310 Wisconsin Street
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T. T. Wellemeyer, MD — FP
4378 W. Holt Road
Holt 48842

Judith M. Yates, MD — IM
3537 W. Front Street
Traverse City 49684

Board of Medicine actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: Allen C. Gorrilla, MD
Action, Date Taken: Limited license (shall not obtain, possess, prescribe, dispense, or administer Con. Sub) effective December 18, 1985.
Reason: Violation of amphetamine rule.

Name: Manoo Moyyad, MD, aka John Moyyad
Action, Date Taken: License revoked, effective December 18, 1985.
Reason: Convicted of a crime reasonably related to and adversely affecting licensure's (sic) ability to practice medicine in a safe and competent manner. (Mail fraud BC/BS)

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicate a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

Date: March 25-29, Family Practice-1986 Tenth Annual Spring Refresher and Board Examination Review. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Jolene Glaspie, Towsley Center (313)763-1400. **Approved for:** 31.5 hours of Category I Credit.

Date: April 1-2, Venous Oximetry. Location: Towsley Center, U-M Ann Arbor. **Sponsor:** U-M Medical School. **Contact:** Betty Phillips, Towsley Center (313)763-1400. **Approved for:** 6.25 hours of Category I Credit.

Date: April 4-6, Differential Diagnosis of Musculoskeletal Pain (with Emphasis on the Low Back). Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing (517)353-9714. **Approved for:** 20 hours of Category I Credit.

Date: April 3-4, 19th Annual Cancer Symposium. Location: Westin Hotel, Renaissance Center, Detroit. **Sponsor:** Wayne State University School of Medicine. **Contact:** Division of Continuing Medical Education, 4-H University Health Center, 4201 St. Antoine, Detroit 48201. **Approved for:** 11.5 hours of Category I Credit.

Date: April 7-9, Hemodynamic Monitoring and Management. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Dove Margenau, Towsley Center-Box 057, Ann Arbor 48109 (313)763-1400. **Approved for:** 14.25 hours of Category I Credit.

Date: April 7-11, Ninth Annual Spring Workshop — Head and Neck Oncology. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Jolene Glaspie, Towsley Center (313) 763-1400. **Approved for:** 43.5 hours of Category I Credit.

Date:April 10, Freud and Literature. Location: Ann Arbor. **Sponsor:** Michigan Psychoanalytic Institute. **Contact:** Michigan Psychoanalytic Institute, 16310 W. Twelve Mile Road, Suite 204, Southfield 48076. **Approved for:** 15 hours of Category I Credit.

Date: April 10-11, Mechanical Ventilatory Support and Management. Sponsor: University of Michigan Medical School. **Contact:** Dove Margenau, Towsley Center-Box 057, Ann Arbor 48109 (313)763-1400. **Approved for:** 14 hours of Category I Credit.

Date: April 11-13, Tutorial on Level I Myofascial Release Technique. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College o Human Medicine. **Contact:** Sandy Kilbourn, MA, Director of Continuing Medical Education, MSU College o Osteopathic Medicine, A306 E. Fee Hall E. Lansing 48824. **Approved for:** 24 hours of Category I Credit.

Date: April 12, Geriatrics Symposium Location: Mental Health Center, Bay City **Sponsor:** Bay Medical Education. **Contact** Dodie Roth, Bay Medical Education, 615 Ninth Street, Bay City 48708 (517)892 1501. **Approved for:** 6 hours of Category I Credit.

Date: April 13, Medical/Surgical Joint Disease. Location: Mt. Pleasant Holiday Inn. **Sponsor:** Central Michigan Community Hospital **For:** General Practitioner, Internists, Pediatricians. **Contact:** Mary Jane Post (517)773-7941 ex. 3090. **Approved for:** 7 hours of Category I Credit.

Date: April 16, Clinical Management o the Elderly. Location: Borgess Auditorium Borgess Medical Center, Kalamazoo **Sponsor:** Borgess Geriatric Center. **Contact:** Charles L. Zeller, MD, 4th Floor Stryker, 1521 Gull Road, Kalamazoo 49001. **Approved for:** 6.5 hours o Category I Credit.

Date: April 16, Psych/Med Day. Location St. John Hospital, Detroit. **Sponsor:** St John Hospital **Contact:** Carol Mastroianni, Program Coordinator (313)343-3877 **Approved for:** 8 hours of Category Credit.

Date: April 16, Child Developement from Birth to Five Years. Location: Ann Arbor **Sponsor:** Michigan Psychoanalytic Institute. **Contact:** Michigan Psychoanalytic Institute, 16310 W. Twelve Mile Road Suite 204, Southfield 48076 (313)559-5855. **Approved for:** 15 hours o Category I Credit.

Date: April 17-18, The Child with Chronic Illness/Disability: A Framework for the Future. Location: MSU, East Lansing **Sponsor:** MSU Department of Pediatrics and Human Development and MSMS. **Contact:** Mary Helfer (517)353-8856. **Approved for:** 12.5 hours of Category Credit.

Date: April 22, 11th Annual Infectious Diseases Symposium. Location: Amway Grand Plaza Hotel, Grand Rapids (1st session); East Auditorium, Butterworth Hospital (2nd session). **Sponsor:** Butterworth Hospital. **Contact:** Celia M. Steel, Continuing Medical Education, Butterworth Hospital, Grand Rapids (616)774-1835. **Approved for:** 6 hours Category Credit (1st session) 1 hour Category Credit (2nd session).

Date: April 23, Cancer Prevention and Early Detection. Location: Genevieve U

CATEGORY I COURSES

Donald S. Gilmore Center for Health ducation, Healthcare Plaza, Kalamazoo. **ontact:** Charles L. Zeller, Jr., MD, MAHEC, Stryker Center, 4th Floor, 1521 ull Road, Kalamazoo 49001. **Approved or** 6 hours of Category I Credit.

ate: April 26-30, Tutorial on Level II lanual Medicine Techniques (Below iaphragm). Location: Kellogg Center, ISU. **Sponsor:** MSU College of Osteopathic Medicine and College of luman Medicine. **Contact:** Sandy ilbourn, Director of Continuing Medical ducation, MSU, A306 E. Fee Hall, East ansing 48824 (517)353-9714. **Ap- roved for:** 40 hours of Category I Credit.

ate: April 28, Annual Orthopaedic Clinic ay. Location: Children's Hospital uditorium, Detroit. **Sponsor:** Children's lospital of Michigan. **Contact:** Sheryl oyd, Program Planner, Children's lospital of Michigan, 3901 Beaubien oulevard, Detroit 48201 (313)494- 456. **Approved for:** 6 hours of Category Credit.

ate: May 1, Michigan Chapter, merican College of Surgeons, Coller ay Competition. Location: Omni Inter- ational Hotel, Detroit. **Sponsor:** lichigan Chapter, ACS. **Contact:** Viola M. leins, MSMS headquarters (517) 37-1351. **Approved for:** 10 hours of ategory I Credit.

ate: May 2, Tenth Annual Preventive ardiovascular Medicine & Rehabilitation ymposium. Location: Martin Verzi uditorium at Borgess Medical Center, alamazoo. **Sponsor:** Southwestern lichigan Area Health Education Center, nstitute for Cardiovascular Health- orgess Medical Center, American Col- ege of Sports Medicine, Michigan Heart ssociation, American Academy of Family hysicians. **Contact:** Jeffery P. Morgan, IA, Borgess Medical Center, 1521 Gull oad, Kalamazoo 49001. **Approved for:** hours of Category I Credit.

ate: May 8-9, The Phlebotomy Team: echnical and Management Perspectives. ocation: Towsley Center, Ann Arbor. **ponsor:** U-M Medical School. **Contact:** olene Glaspie, Towsley Center (313) 63-1400. **Approved for:** 10.75 hours of ategory I Credit.

ate: May 15, Perinatal Passages. Loca- ion: Western Michigan University Student enter, Kalamazoo. **Sponsor:** South- vestern Michigan Perinatal Association, outhwestern Michigan Area Health ducation Center and American Academy of Family Physicians. **Contact:** Wendy insterwald, Southwestern Michigan erinatal Associaton, 252 E. Lovell Street, alamazoo (616)383-6469. **Approved or:** 5.5 hours of Category I Credit.

ate: May 15, MSMS Sports Medicine onference. Location: Clarion Convention enter. **Sponsor:** MSMS. **Contact:** Sherry ent, MSMS headquarters (517)337-1351. **pproved for:** 5 hours of Category I redit.

Date: May 16, Physiological Monitoring. Location: Gilmore Health Education Center, Kalamazoo. Sponsor: Bronson Respiratory Care Department, Southwestern Michigan Area Health Education Center. **Contact:** Phyllis J. Wilson, Respiratory Care Department, 252 E. Lovell, Kalamazoo 49007. **Approved for:** 6 hours of Category I Credit.

Date: May 17-18, Michigan Society of Pathologists Immunopathy and Fine Needle Aspiration Lesions. Location: St. Clair Inn, Port Huron. Sponsor: Michigan Society of Pathologists. **Contact:** Viola M. Heins, MSMS headquarters (517) 337-1351. **Approved for:** 8 hours of Category I Credit.

Date: May 21, The Brain and the Heart — A Current Look. Location: Gilmore Health Education Center, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Chris Pearson, SMAHEC, 4th Floor, Stryker Center, 1521 Gull Road, Kalamazoo (616)383-6360. **Approved for:** 6 hours of Category I Credit.

Date: May 28-30, Current Topics in Blood Banking, 13th Annual Symposium. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Betty Philips, Towsley Center (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: May 28-June 1, Tutorial on Direct Action Thrust Manipulative Technique. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: June 9-13, Principles of Manual Medicine. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine, College of Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: June 12-14, 37th Annual Keyport-Gaylord Trauma Symposium. Location: Hidden Valley Club, Gaylord. **Sponsor:** Wayne State University School of Medicine. **Contact:** Robert F. Wilson, MD, Wayne State University Department of Surgery, 6-C UHC, 4201 St. Antoine, Detroit (313)577-5009. **Approved for:** 15 hours of Category I Credit.

Date: July 24-25, Collier Penberthy Thirlby Medical Conference. Location: Grand Traverse Resort, Grand Traverse Village. **Sponsor:** Munson Medical Center. **Contact:** Norma Powers, Coordinator of Medical Education, Munson Medical Center, 6th and Madison, Traverse City 49684 (616)922-9544. **Approved for:** 9 hours Category I Credit.

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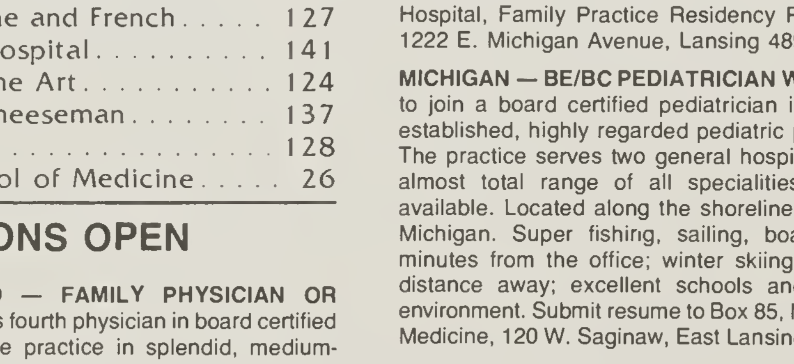

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By Richard J. McMurray, MD

AIDS — the plague of the 80s

In the summer of 1981 the weekly newsletter published by the US Public Health Service's Center for Disease Control (CDC) carried a brief comment on an unusual outbreak of rare cancers and lung infections in five young homosexuals in Los Angeles. Similar reports followed shortly thereafter from New York City and San Francisco.

Later that year the *New England Journal of Medicine* published several articles describing the appearance of these same illnesses in both homosexuals and intravenous drug abusers and suggested that the victims' immune systems were severely deficient. The CDC soon labeled the new disorder Acquired Immune Deficiency Syndrome (AIDS), and subsequent evidence established that AIDS was both transmissible and extraordinarily lethal.

More than 14,000 cases have been reported in the United States alone, and the total is expected to reach 40,000 by the end of 1986. Because of its association with sexuality and drug abuse, as well as its lethality, the AIDS epidemic has generated great public alarm and controversy.

A startling challenge

In a time of vaccines, antibiotics and other medical advances, the outbreak of a new transmissible, universally fatal, and thus far uncontrollable disease is a startling challenge to medical science. Progress toward containment of the AIDS epidemic seems painfully slow to an alarmed public, especially to those who are most at risk and who unknowingly may be carrying the AIDS virus.

Though small comfort to the victims of this disease, half of whom already are dead, only three years passed from the first outbreak of AIDS in the USA to a comprehensive understanding of its cause. It might still be an enigma if we didn't enjoy the advances we have attained in the last two decades in neurology, immunology and molecular biology.

AIDS controversy

The fear that AIDS may spread from the homosexual community and other high-risk groups to the general population has provoked strong controversy and demands that restrictions be imposed on victims of the disease. Even children who acquired AIDS from tainted blood transfusions have been stigmatized as carriers of a modern-day equivalent of the bubonic plague and threatened with social isolation.

The ethical issues arising from the AIDS epidemic are clouded by continuing public uncertainty about the true nature of the disease, how it is transmitted, and the significance of antibodies to the AIDS virus in the blood of persons who have been exposed to AIDS but have yet to show any signs of illness.

Apart from issues of confidentiality, more immediate ethical problems face many physicians and health workers. They are called upon daily to care for AIDS patients, at some risk to themselves, and to decide what is appropriate care for terminally ill patients.

Many critics believe that insufficient funding has limited effective surveillance activities and epidemiological studies and thus thwarted the ability of medical researchers to respond promptly to this serious disease threat. Although adequate funding is now in place for AIDS research we are faced with the critical and growing burden of caring for AIDS patients in an already financially burdened health care delivery system. Doctor June Osborn, dean of the University of Michigan School of Public Health believes that at present our best opportunity for coping with the AIDS epidemic is prevention, and our greatest hope of prevention rests largely on our ability to modify human behavior.

AIDS brochure

MSMS has published a brochure entitled "AIDS Update" for enlightening the general public regarding this serious disease.

Your society journal, *Michigan Medicine*, is happy to enlighten the membership by presenting a Special Report in this issue focusing on AIDS as prepared by Evelyn J. Fisher, MD, of Detroit. We thank you, Doctor Fisher, for this timely report. ☐

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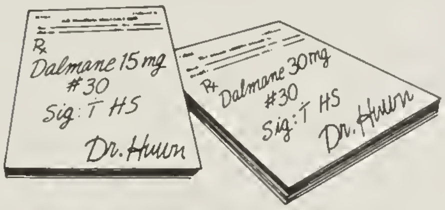

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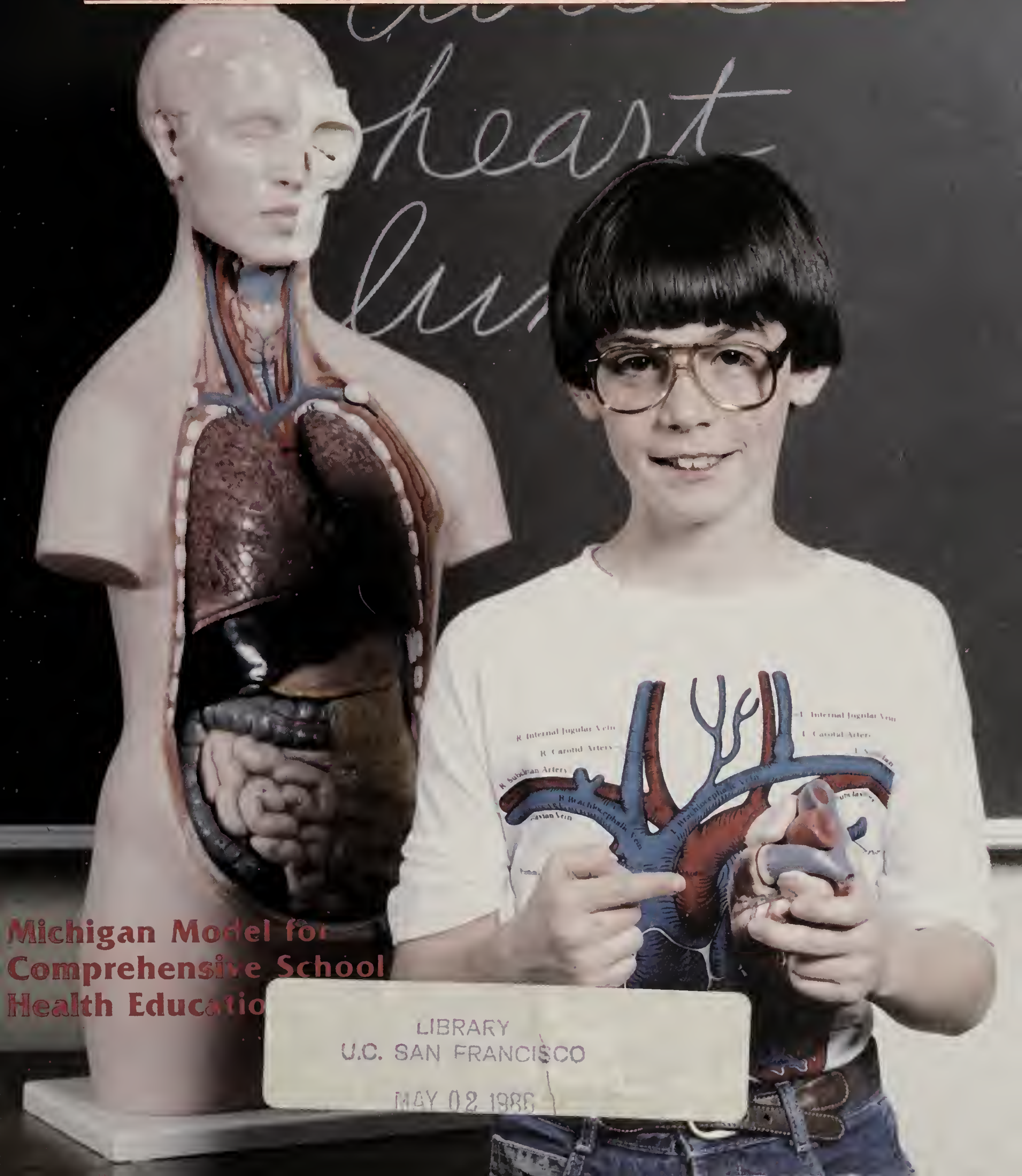

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Michigan Model for Comprehensive School Health Educatio

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April 1986, Vol. 85, No. 4

MICHIGAN MEDICINE

About the cover:
Early health education helps prepare children to make lifestyle choices as adults.
Photo by Kim Kauffman.

Special report

148 By the end of this school year, more than 70,000 Michigan school children will have participated in the Michigan Model for Comprehensive School Health Education curriculum. It's a learning program that unites the best features of existing programs to bring wellness education to K-6 graders. The implementation of this program requires professional and community support; Roxanne DeWeerd, James T. Harrison, MD, and Donald Ben Sweeney.

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By Louis R. Zako, MD

The greening of health care

The past decade has witnessed dramatic scientific and technologic advances in medical and health care. The results have been startling and gratifying. Life expectancy has increased significantly and in countless cases the quality of life has improved remarkably. Older citizens now live several years longer and need not hobble painfully on degenerative hips and knees. Middle-aged Americans increasingly are treated in the early hours of a heart attack with intra-coronary streptokinase or angioplasty. Americans of all ages now have (in spite of insane certificate-of-need legislation) the option of having kidney stones shattered while taking a bath rather than surgically excised in the operating room. Tiny premature infants confound us daily with the ability, thanks to modern technology and highly skilled and dedicated neonatologists, to survive and to grow to productive adulthood.

One would think that the whole nation would rejoice at the good news. After all, we hear daily that our nation's wealth should be employed to help the poor, the homeless, the needy, rather than to build weapons of destruction. Fascinatingly, however, we have somehow developed a schizophrenic attitude toward the sick. For them we increasingly offer denial of technology, denial of necessary hospitalization, premature discharge from the hospital, and alternative health plans devised first and foremost to save money. Further, while as a people we struggle with how to improve the incentives for our brighter students to become math and science teachers, we are embarked on a mission to make a career in medicine less attractive, both in terms of professional satisfaction and in financial terms.

There is little question that in the foreseeable future the average physician's real income will decline. Faced with a growing surplus of physicians, the continuing decline of private and fee-for-service practice, the escalating cost of malpractice insurance, and the freezing of fee reimbursement by both government and other third party payors, the average physician faces enormous economic pressures. Paradoxically, however, others see great economic opportunity in health and medical care. After all, health care is an enormous industry, with enormous profits to be earned.

While our nation, which in the past has been satisfied to see its physicians earn a comfortable living, now is bent on limiting that comfortable living, it appears to be relatively undisturbed while investors move in to syndicate and to make potentially vast profits on care of the sick. We now see lawyers, real estate developers, business school graduates, state and federal regulators, consultants (the non-medical types), and even organized crime getting a piece, a very big piece, of the action. No longer do we see a small community hospital run by a nun, a small town physician administrator, or a nurse-turned-administrator. Instead, we witness

Continued on next page

Doctor Zako is a member, MSMS Board of Directors, and MSMS Committee on Publications.

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mergers, management contracts, for-profit chains and administrators from out of town. We also witness almost half of our physicians receiving all or some of their incomes from salaries, rather than directly from satisfied or dissatisfied patients.

What are the long-term implications of such dramatic changes in the financial aspects of health care? Will patients generally be better off or less well off? Will a patient on Medicaid or without any insurance get better care from a hospital with community roots or from a hospital owned and operated by out of state lay investors? Will a poor patient get a better break from a family physician who has known this patient for years and who derives most of his or her income from patient fees, or from a physician on salary with a large HMO or on contract to a PPO organized by shrewd businessmen? Will health planning regulators recognize that surgically removing many kidney stones is not only more expensive, but much less pleasant for those they are paid to represent than shattering stones with sound waves?

No one really knows the answers to these questions. I do know personally that, in many ways, it is better to have been a patient, rich or poor, in the 70s and early 80s than to be a patient in the latter half of the 80s. Further, growing numbers of bright and idealistic young people are deciding that it is simply not worth the sacrifice to be a physician. What happens to our nation's doctors and our nation's hospitals is less important in the final analysis than the impact upon our entire population. I hope we are wise enough to make the right choices in the future.☐

Physicians and civic duty

I should like to provide a prompt and direct answer to Senator Vern Ehler's question: "Why aren't physicians the pillars of their communities any more?" (*Michigan Medicine*, Feb., 1986).

The professional life of the average physician has become an all-consuming effort to keep up with rapid scientific progress, to comply with a profusion of legislated regulations, to stave off escalating threats of legalized extortion. We are also trying to meet the mushrooming demand of health care consumers for empathy, guidance, education and counseling. Where is there room for political activity and civic leadership, not to speak of adequate rest and recreation?

It is no secret that the families of physicians have been suffering unduly from the compulsive urge of physicians to respond to the call of duty. We do not need more exhortations to do the impossible. What we need is a set of more realistic job descriptions for physicians—and perhaps for legislators as well.

Gustav A. Uhlich, MD
Petoskey

By James T. Harrison, MD

Wellness curriculum developed for Michigan's school children

As physicians, we know that many of the diseases and conditions requiring medical care need not be inevitable consequences of living. Rather, with a sound informational base that explains and demonstrates the relationship between lifestyle and illness, individuals can change their health-related attitudes resulting in healthier living habits. We also know that health education aimed at children before many lifestyle decisions are made will have a much better chance of success.

Because both the American Medical Association and the Michigan State Medical Society have long been supporters of school health education, I am pleased to provide an overview of Michigan's effort to bring wellness to our school aged children.

Over the past decade, our encouragement of health education in schools has fostered many programs, all well-intended but mostly narrowly focused on categorical health issues. This led to competition among these programs for the very limited time that schools lend to health education.

What was needed was not a new curriculum to further compete with other programs, but a framework that could unite the best features of all the existing school health education programs under one comprehensive umbrella. This framework then could be logically supported by various local and state organizations; it could facilitate in-service training for teachers; and provide a basis for our schools to systematically plan, implement and evaluate health education.

These considerations led to the organization of the Michigan Model for Comprehensive School Health Education.

The Michigan Model was implemented in 1984/85 and by the end of this school year, its second year, more than 70,000 children will be participating in nearly 100 local Michigan school districts. Our success in implementation is due to several factors: The first is visible state commitment—the Michigan Model funding has separate line items in the state budget, none of which are for state agency support. The Governor's recommendations for 1986/87 are for $1,888,000 in State School Aid, and $307,500 in the Public Health budget.

The second factor is state coordination. I have the privilege of chairing the state-agency steering committee that is responsible for overall implementation of the Michigan Model. The seven state agencies represented on the steering committee are: the Departments of Education, Mental Health, Public Health, and Social Services, and the Offices of Health and Medical

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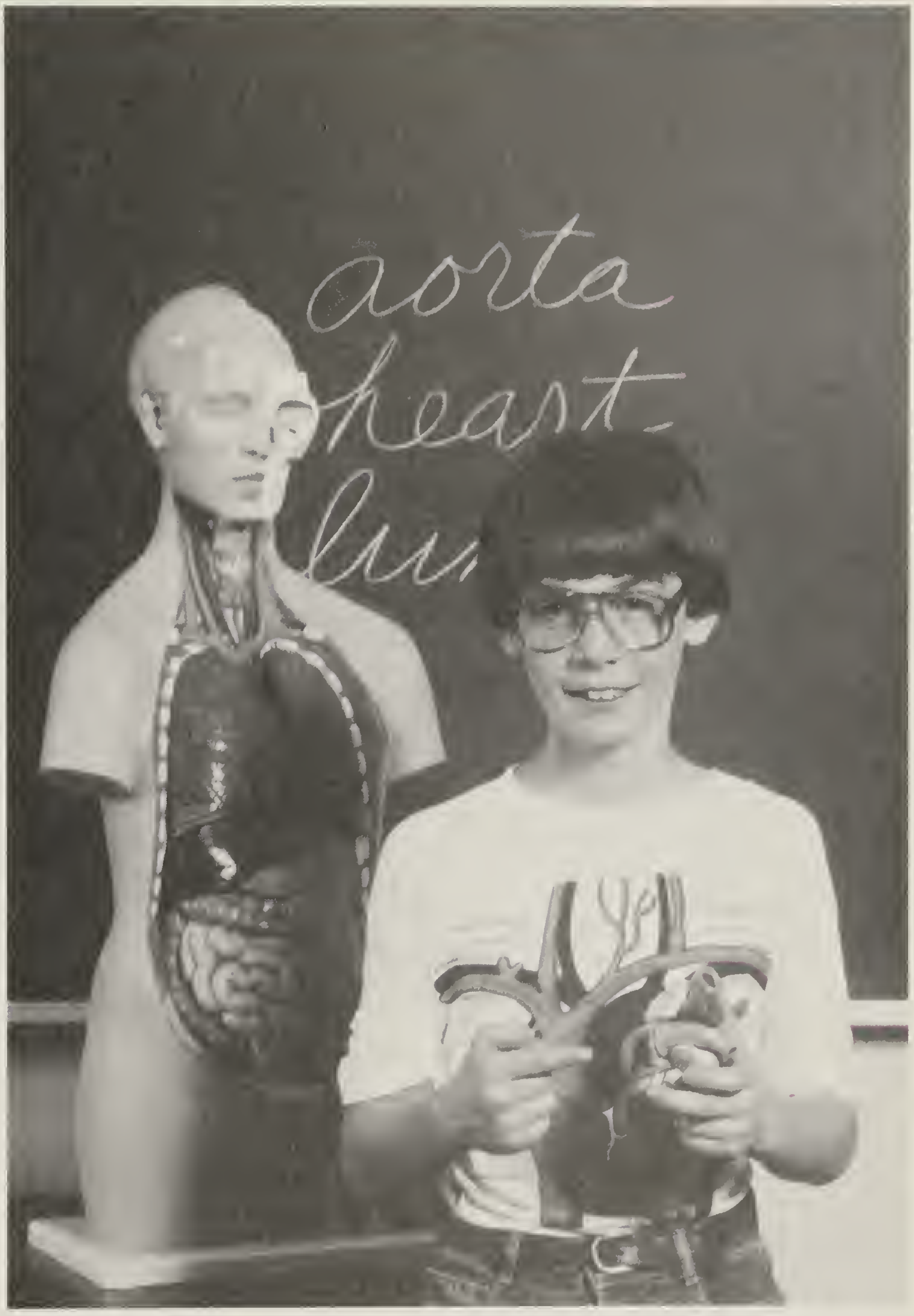
Doctor Harrison is chief medical officer and deputy director of the Michigan Department of Public Health, and chairman, Michigan Model State Steering Committee.



Affairs, Highway Safety Planning, and Substance Abuse Services. We are attempting through the steering committee to organize our expertise and resources to further the implementation of the Michigan Model. Our efforts to date, I believe, are exemplary of what state government and local and state organizations can do together.

The final factor, and probably the most critical, is a supportive network of Michigan Model coordinators. The coordinators are employees of selected intermediate and local school districts throughout Michigan. Their responsibility is the facilitation of in-service training of teachers at the local level, rotation of material used in instruction, local promotion of the Michigan Model through a local steering committee, and participation, with local school administrators, of implementation schedules.

While we have a fine beginning, total statewide implementation will take years to accomplish. We will, therefore, need constant support at both the state and local levels. Because this program is not responding to a "crisis," we face the risk of complacency by our supporters with regard to funding and to the overall need. The following information should lend an urgency to our efforts: In 1985, health education was tested in 250 school districts as part of the Michigan Education Assessment Program (MEAP). A sample of students who took the test at each of three grade levels (4, 7, 10) was used to assess the level of statewide achievement in health education knowledge. Results of the sampling show that 55.1 percent of the fourth graders had acceptable scores, 35.7 percent of the seventh grade scores were acceptable and 22.3 percent of the tenth grade scores were acceptable.

As State Superintendent of Instruction Phillip Runkel stated, "This sampling of the health education test shows much work needs to be done to improve the knowledge level of students about health."

Physicians can contribute to the implementation of the Michigan Model through participation with local steering committees, endorsement of Michigan Model efforts with school administrators and contacts with legislators.☐

By Roxanne DeWeerd

Health education is an important basic

Photos by Dan Broyhill

Sixth grade students dissecting pig hearts? Fifth grade boys and girls examining and dissecting pig plucks? Dissecting sheep eyes in second grade?

Yes, this and much, much more is incorporated in the Michigan Model for Comprehensive School Health Education, a state supported school health curriculum in its second year of statewide implementation. The curriculum is a cooperative effort of seven state agencies: Michigan Department of Education, Michigan Department of Public Health, Office of Substance Abuse Services, Michigan Department of Mental Health, Office of Highway Safety and Planning, Department of Social Services, and the Office of Health and Medical Affairs. The curriculum is currently being implemented in approximately 97 school districts throughout Michigan. Twenty-two Intermediate School Districts and four large cities (Flint, Grand Rapids, Detroit and Lansing) have received funds to implement the health curriculum in their regions.

The Michigan Model is an exciting K-6 curriculum that includes thorough instruction in the content areas of disease prevention and control, personal health practices, nutrition, growth and development, family health, substance abuse, consumer health, safety and first aid, community health and mental health at each grade level. The focus of the entire curriculum is on *prevention* and *wellness*. It is believed that if children learn positive health practices at an early age, they can reduce risk of chronic diseases in adulthood.

Creative approach

The curriculum is a "hands on," creative program differing

Ms. DeWeerd is Health Consultant for Kent Intermediate School District. She currently is training teachers in Kent, Ionia and Montcalm counties in the Michigan Model for Comprehensive School Health Education.

from the typical didactic textbook approach. Learning stations, accompanied by dissections and other activities, make this curriculum exciting for teachers and children alike. In addition to simple memorization of parts and function of the lungs, for example, students have opportunity to actually feel and examine lungs, as well as inflate them with a bicycle pump to get a greater appreciation for their function. Teachers are provided with thousands of dollars worth of instructional materials such as models, filmstrips, movies and charts to make lessons "come alive."

One major component of this health project is the provision for teacher training in the area of health. Most teachers confess they would be unable to implement the program without the required 30 hours of training—most have never had a health course in their professional studies. Teacher training has included vast numbers of community resource persons who graciously have volunteered their time and expertise to assist in teacher instruction.

In the Grand Rapids area, for example, the Kent County Health Department has provided speakers on dental health, communicable diseases and wellness, as well as computerized health risk appraisals for all participants. In addition, Doctor Richard Tooker from the Kent County Health Department has presented information/statistics on AIDS and sexually-transmitted diseases for educators of reproductive health. Doctor Jeffrey Frank, local obstetrician/gynecologist, provided educators with valuable information on birth control and fetal development. Physicians from St. Mary's Hospital, Doctor David Blair and Doctor Donald Barbachym, Metropolitan Hospital, have discussed the importance of "wellness."

In addition, local college and university professors have lectured on anatomy, physiology and environmental issues. The YWCA has provided valuable information on child sexual abuse, and organizations such as American Lung Association, American Heart Association and American Cancer Society have donated valuable instructional materials.

Support needed

The Michigan Model for Comprehensive School Health Education requires strong community-based support in order to be viable. The interest and willingness of professionals such as doctors, dentists, and university personnel give teachers the clear message that health is important, and is indeed, basic! Funding levels of this project always are in jeopardy, therefore any support health professionals can share with legislators would be beneficial. Support the Michigan Model for Comprehensive School Health Education in your area.☐

By Donald Ben Sweeney

Involving parents in the schools

What did you do in school today?

> **". . . terrific idea to make children aware of what is good for their bodies and how good habits will carry through all their lives."**
>
> **". . . a needed subject for all of us—young and old."**
>
> **". . . great—helped my children and I become even closer."**

These are some of the many positive comments from more than 300 households responding to a survey of parents taking part in the Michigan Model for Comprehensive School Health Education. Those parents who made up this non-scientific sampling responded with overwhelming support for the school health education program, a willingness to participate in the educational process and a belief that health education had a positive impact on their child's behavior. The findings of the survey indicated that parents feel that:

- Health education is a great idea (80 percent), 20 percent felt it is a good idea;
- 96 percent of students were incorporating one or more positive health behaviors.

Since being involved in the health program:

- 60 percent of children brush their teeth more often;
- 51 percent are more aware of substance abuse;
- 48 percent wash their hands more often;
- 31 percent use seatbelts more often.

The parent component of the Michigan Model is considered to be one of the key components of this comprehensive health curriculum. The health program involves parents by: 1) making them aware of what is being taught; 2) suggesting activities for the home to reinforce what is being done in the classroom; 3) asking for sug-

---

Mr. Sweeney is with the Center for Health Promotion, Michigan Department of Public Health.

gestions and evaluation of the curriculum, and 4) suggesting community resources. The parent component adds a strength and dimension to this health curriculum that has not been available in many teaching situations.

Common sense

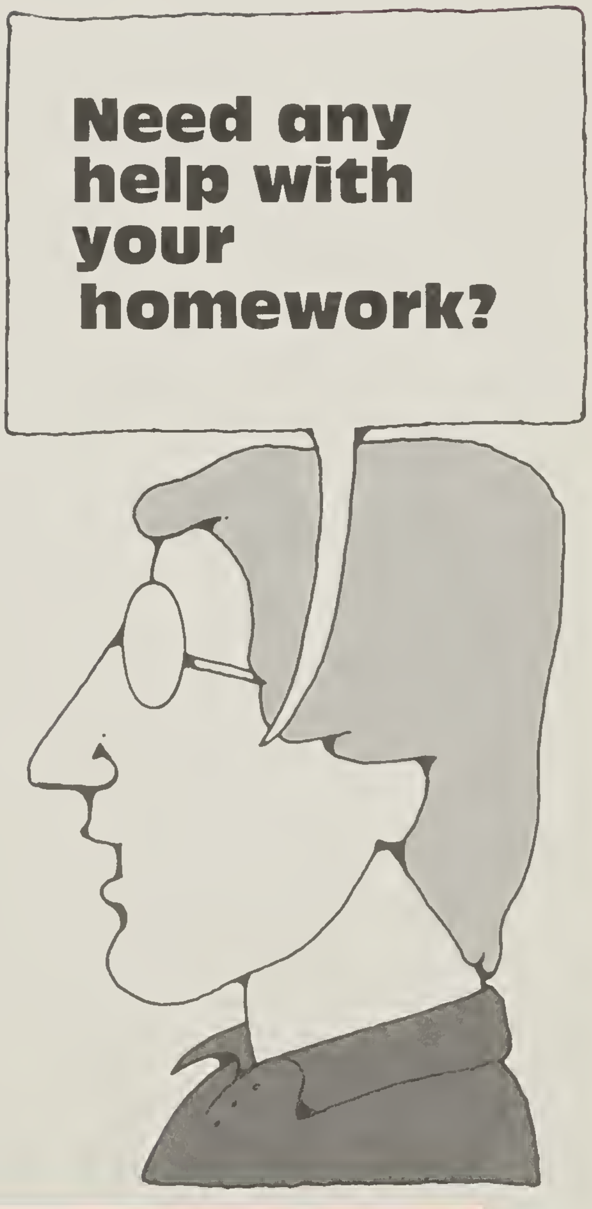
Much of the message in health promotion/health education is the good common sense that most of us learned at home. A research study of 6,928 adults from 1965 to 1974 indicated that any six of the following health promotion practices add 11 years to the life expectancy of males and seven years for the women in the study:

- Don't smoke;
- Get regular exercise;
- Moderate or discontinue use of alcohol;
- Maintain proper weight;
- Get seven to eight hours of sleep daily;
- Eat breakfast;
- Don't eat between meals.

This is the basic advice that mom gave us all. The Michigan Model for Comprehensive School Health Education makes parents aware that it is reinforcing and building on the good health practices they teach at home. When we can create a partnership between the school and home we have a tremendous potential for positive impact on the health knowledge, attitudes and behaviors of our chldren.

The input of parents in cooperation with the schools, the community, and voluntary and professional groups make this a successful program.

The implementation of this wellness model requires active professional and community support. Contact your local intermediate school district and become involved in the effort to provide quality health education programs to children in your community.☐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MSMS opinion leaders briefed on professional liability tort reform efforts

MSMS, county and specialty society leaders learned of the latest legislative thinking on liability reform at a March 5 briefing in Lansing. Rep. Lewis Dodak (D-Montrose), left, chairman of the House "pre-conference committee" on reform, described his anti-cap position to interested physicians at the all-day session. ***Photos by Pattrick Yockey.***

MICHIGAN STATE MEDICAL SOCIETY
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Sen. Dan L. DeGrow (R-Port Huron) told the 50 leaders at the briefing that the Senate had not changed its position on liability reform since October 22, the date of the "Onward to Lansing" physician rally. *More photos on next page.*

Richard A. Stone, MD, Mt. Clemens, president, Macomb County Medical Society, was among physicians asking hard questions of the legislators and other speakers. Later, the group visited local legislators in their Lansing offices.

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Speakers for the morning session, from left, included MSMS President-elect Thomas R. Berglund, MD; MSMS Secretary Robert M. Leitch, MD, who also is president of the Michigan Physicians Mutual Liability Company; MSMS Board Chairman Carl A. Gagliardi, MD; MSMS President Richard J. McMurray, MD; MSMS Legal Counsel Richard Weber, and MSMS Professional Liability Task Force Chairman Louis R. Zako, MD.

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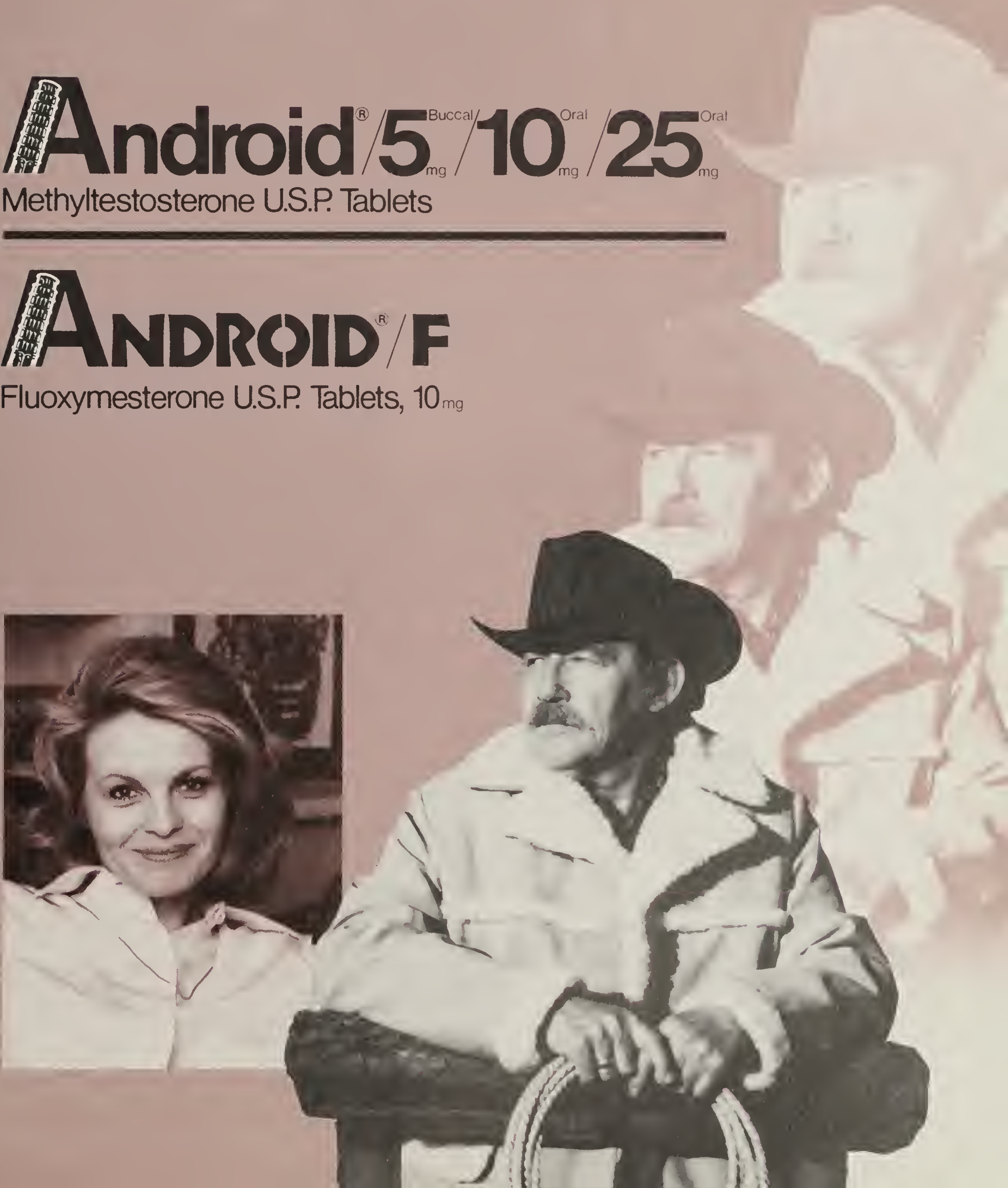

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Linda Bove performed with The National Theatre of the Deaf for nine years. She has also starred in the Tony Award winning show, *Children of a Lesser God.*

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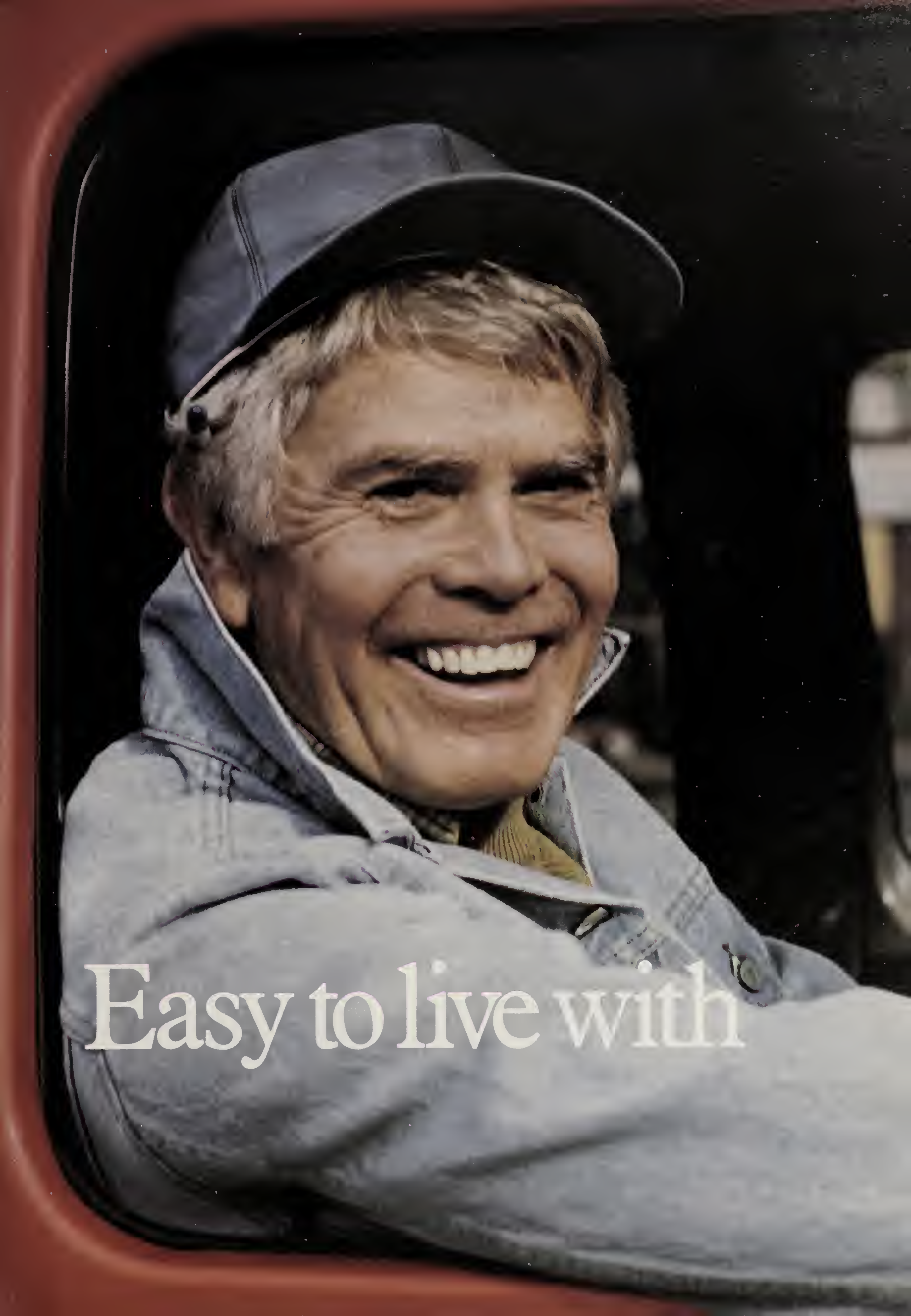
AMA President-elect says "thanks"

John Coury, MD, AMA president-elect, thanked the MSMS Board of Directors at its January 22 meeting for its support during his candidacy and throughout his career. Doctor Coury, a Port Huron general surgeon, will assume the office of AMA President in June. He is pictured below with MSMS President Richard J. McMurray, MD. ***Photos by Pattrick Yockey.***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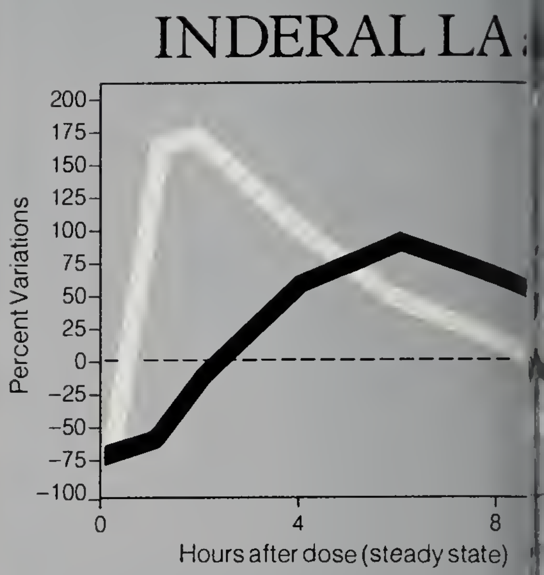

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Once-daily
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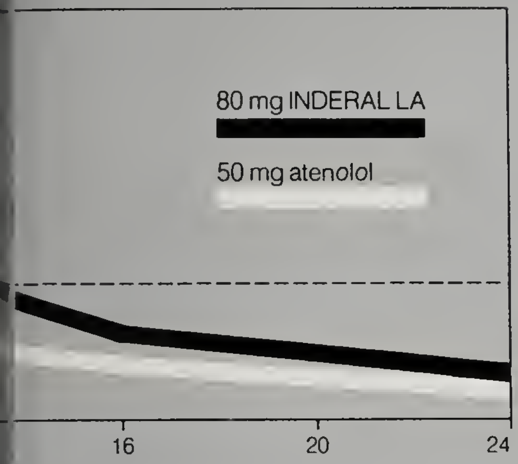
(PROPRANOLOL HCl) **Long Acting Capsules**

Please turn page for brief summary of prescribing information.

nolol over 24 hours*[1]



asma concentrations in relation to the mean.

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(HYDROCHLOROTHIAZIDE)

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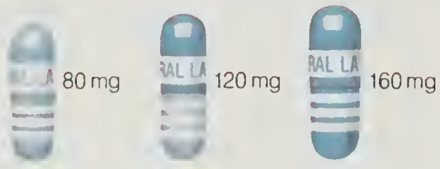

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INDERIDE® LA
Each capsule contains propranolol HCl (INDERAL LA), 80 mg, 120 mg, or 160 mg and hydrochlorothiazide, 50 mg*

80/50
120/50
160/50

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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULARS.)*

INDERAL® LA Brand of PROPRANOLOL HYDROCHLORIDE **(Long Acting Capsules)**
INDERIDE®LA Brand of PROPRANOLOL HYDROCHLORIDE (INDERAL® LA) and HYDROCHLOROTHIAZIDE **(Long Acting Capsules)**
INDERAL LA AND INDERIDE LA Capsules should not be considered simple mg-for-mg substitutes for INDERAL and INDERIDE Tablets. Please see package circulars

CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL® LA): Propranolol is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs

WARNINGS

Propranolol hydrochloride (INDERAL® LA): CARDIAC FAILURE Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction following *abrupt* discontinuance of propranolol therapy Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm Propranolol does not distort thyroid function tests

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution, since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes In these patients, it may be more difficult to adjust the dosage of insulin Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS

Propranolol hydrochloride (INDERAL® LA): GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test Withdrawal may lead to a return of increased intraocular pressure

CLINICAL LABORATORY TESTS Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs, such as reserpine should be closely observed if propranolol is administered The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential In 18-month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity There were no drug-related tumorigenic effects at any of the dosage levels Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug

PREGNANCY Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS Propranolol is excreted in human milk Caution should be exercised when propranolol is administered to a nursing mother

PEDIATRIC USE Safety and effectiveness in children have not been established

Hydrochlorothiazide: GENERAL Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely Hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes Warning signs irrespective of cause are. Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult

NURSING MOTHERS. Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing

PEDIATRIC USE Safety and effectiveness in children have not been established

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL® LA): Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy

Cardiovascular: Bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss; emotional lability; slightly clouded sensorium; and decreased performance on neuropsychometrics.

Gastrointestinal. Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation; mesenteric arterial thrombosis; ischemic colitis

Allergic. Pharyngitis and agranulocytosis; erythematous rash; fever combined with aching and sore throat; laryngospasm and respiratory distress.

Respiratory: Bronchospasm

Hematologic: Agranulocytosis; nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported

Miscellaneous. Alopecia, LE-like reactions, psoriasiform rashes; dry eyes; male impotence; and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol

Hydrochlorothiazide:

Gastrointestinal: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation; jaundice (intrahepatic cholestatic jaundice), pancreatitis; sialadenitis.

Central Nervous System. Dizziness, vertigo; paresthesias; headache; xanthopsia.

Hematologic: Leukopenia, agranulocytosis; thrombocytopenia; aplastic anemia

Cardiovascular. Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity Purpura, photosensitivity; rash; urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis); fever, respiratory distress, including pneumonitis; anaphylactic reactions.

Other. Hyperglycemia, glycosuria; hyperuricemia, muscle spasm; weakness; restlessness; transient blurred vision

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

REFERENCES

1. Data on file, Ayerst Laboratories. **2.** Ravid M, Lang R, Jutrin I: The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985,145.1321-1323 **3.** Sumiye L, Vivian AS, Frisof KB, et al: Potassium loss associated with hydrochlorothiazide versus chlorthalidone. *Clin Ther* 1981;4 308-320. **4.** Ram CVS, Garrett BN, Kaplan NM. Moderate sodium restriction and various diuretics in the treatment of hypertension. *Arch Intern Med* 1981,141.1015-1019

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By Ted Roelofs

MSMS President-elect Berglund enters his third decade of medical politics

"I've always been interested in legislation and politics. I got involved in the political aspect of medicine in the early 1960s."

QUARANTINE
SKI FEVER

Ask a kid of seven or eight what he wants to be when he grows up and you'll probably hear something like: "I want to be a fireman. I'm going to play ball for the Detroit Tigers. I'm going to drive a big truck."

If you had asked Thomas Berglund the same question 45 years ago, you would have heard: "I'm going to be a doctor."

The incoming president of the Michigan State Medical Society says he knew from the time he was in first grade what he wanted to do.

"I don't know why, it's just something I was always sure

Continued on next page

Mr. Roelofs is a Grand Rapids freelance writer.

of," says Berglund, 52, a Kalamazoo resident who will begin his one-year term next month.

You might expect that Berglund grew up in a family of doctors, but his father was a pharmacist. Home to him as he grew up was Newberry, "a thriving metropolis," as Berglund describes it, in the eastern side of the Upper Peninsula.

Involvement

Berglund may have been sure of his vocation, but he had no way of knowing that his career as a doctor would be paralleled by decades of involvement in the politics of medicine and in community volunteer work. And growing up in the flatlands of the UP, he probably never guessed he would someday fall in love with the ski trails of Colorado or Australia.

Doctor Berglund relaxes with his family around him: from left to right, family members are son-in-law Tom Curran, daughter Tracy Curran, Doctor Berglund, his wife Jill and son Tom, Jr.

Somehow along the line, Berglund has found time to establish a thriving family practice, work diligently on state and federal medical issues, donate thirteen gallons of blood to the Red Cross, marry, raise a family— and become a terror on the downhill ski slopes.

"I love skiing," says Berglund, a far-away look creeping into his eyes— but more on that later.

Berglund attended Newberry schools until his junior year when his family moved to Standish. After graduation from high school, he enrolled in the pre-med program at the University of Michigan. He graduated from U-M Medical School in 1959. He served both his internship and residency at Bronson Methodist Hospital in Kalamazoo, and established his practice in Portage in 1961.

It was clear from the beginning of his medical career that Berglund wasn't one to sit on the sidelines.

"I've always been interested in legislation and politics. I got involved in the political aspect of medicine in the early 1960s."

He remembers well the controversy of the time.

"Medicare and Medicaid were the issues that I first got involved in, in 1963 and 1964. There was the perception that was the early advent of socialized medicine."

Today Berglund is convinced that the federal government "sold us a bill of goods" when it established those programs.

"They were much more costly than the government said they would be and now they are refusing to pay. If the government is going to set a responsibility then it should assume responsibility for its funding."

There were state issues as well. Berglund was chairman of the MSMS Committee on State Legislation and Regulation in the early 1970s. This time, he fought political battles he was able to help win.

Pending at the time in the legislature were two bills, one which would ban lead in paint and one to mandate the use of safety plate glass. Both were stalled in committee.

Berglund and others were able to persuade the respective committee chairmen to let the bills see the light of day. They did, and the bills passed.

Years of time and effort later, Berglund was named 1985-86 chairman of the American Medical Political Action Committee.

MSMS leader

Berglund also is past chairman of the MSMS Public Relations Committee, director of the fourth district from 1977 to 1985, vice chairman of the Board of Directors, and chairman of the Board from 1981 to 1985.

Continued on page 168

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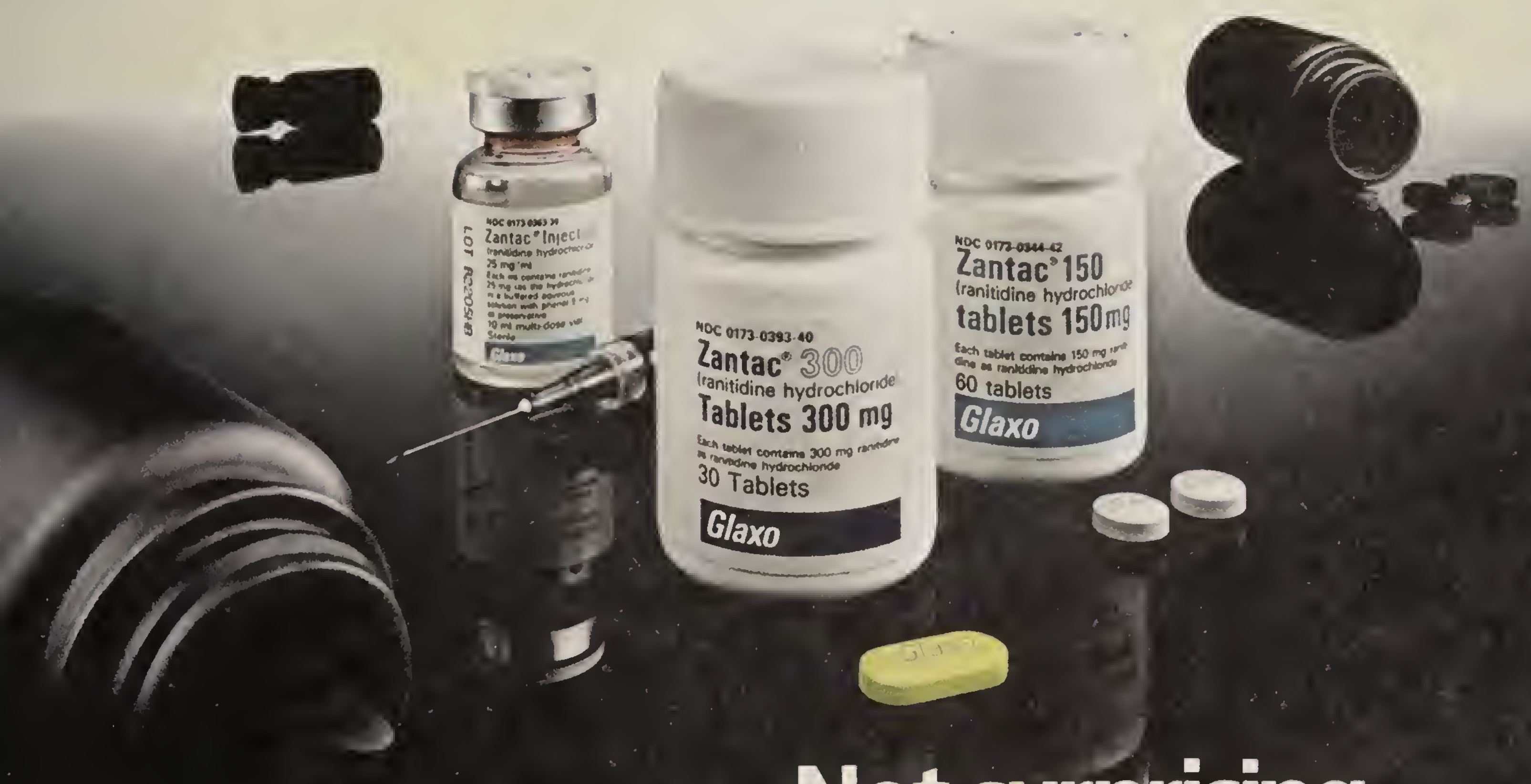
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March 1986

The Berglunds enjoyed a ski vacation with the family in Zürs, Austria this past winter.

He's also donated hours of time (as well as the thirteen gallons of blood) to the Red Cross. He is currently medical advisor to the Kalamazoo Chapter of the American Red Cross.

As president of MSMS, Berglund says he has no specific agenda other than to "make a bridge" between the state society and its grassroots membership. "I'd like to visit as many of the component county societies as I can," he says.

But Berglund is not about to stay out of the political fray. One ugly word—malpractice—keeps rearing its head, and Berglund does not think it's about to disappear.

I wish I had a simple answer," he says. "But there are a lot of components to it and I don't think there is going to be any simple, quick fix.

"We have to get right at the root of things. There have to be some changes in our tort system. It's not just medical malpractice. I think it touches everybody.

"Why a guy can go into a bar and have a beer and then go to ten other bars, and the first bar is liable, is beyond me. There have to be some basic changes."

Berglund points to Indiana, where there is an absolute cap of $500,000 on malpractice awards, as a model approach to the problem. He is doubtful, however, that Michigan legislators will adopt such a limit. "I think that is *very* wishful thinking," he says.

Last fall's march on the capitol by some 10,000 doctors protesting malpractice costs may not win the battle, Berglund believes, but it probably awakened many potential activists.

"I think some of our doctors have finally come to the realization that stuff in Washington, stuff in Lansing is affecting them," says Berglund. "One thing the march did do is get an awful lot of people (physicians) to start becoming involved."

The big issues

There are other issues to be addressed, says Berglund: the decrease in Medicare payments; abortion; the Baby Doe question.

"Abortion, I think, is always going to be there."

As for the ongoing preoccupation with AIDS, Berglund is convinced that public knowledge and understanding are vital.

"It's a real problem, but it's been way overblown almost to the point of hysteria. If we can get people to listen, I think they will calm down."

Berglund is convinced that Health Maintenance Organizations are here to stay, and rightfully so, he believes. He estimates that ten to fifteen percent of the patients at his group practice are from an HMO.

"It's just a different method of payment," he says. "You know, an awful lot of people think it's the greatest thing since sliced bread. A lot of times, patients get better care.

"Doctors have adapted to tremendous changes in medicine over the years, but they have a hard time adapting to a change like this.

"There is a place for HMOs. We live in a pluralistic society and there is a place for all (methods of payment)."

Berglund has taken care to maintain his own health through a regular—or as regular as possible—program of exercise. He plays handball, rides a stationary bicycle and jogs to stay in shape. "I try to do it four times a week, but sometimes that's difficult," he says.

He also skis, but that belongs in a different category from the other activities. That's more like a passion.

Earlier this winter, Berglund, his wife Jill and their two children, Tracy and Thomas Jr., managed to break away for a ski vacation in Zurs, Austria.

"I'm getting more cautious as I get older," says Berglund, who nonetheless tackles some mountain slopes that would give novice skiers heart palpitations.

"I love to ski."☐

PHYSICIANS IN THE NEWS

Butman

Kozonis

Rupke

Zuidema

John W. Rebuck, MD, of Birmingham and **Emerick Szilagi, MD,** of Bloomfield Hills recently were honored by Henry Ford Hospital with Distinguished Career Awards for their contributions to patient care, medical education and scientific advancement at the hospital. . . .**Keith Burch, MD,** of Bloomfield Township was named medical director of Ford Hospital's West Bloomfield Center. He is the team physician for the Detroit Lions.

. . .**Robert E. Wilson, MD,** Battle Creek, secretary of Calhoun County Medical Society, recently obtained the rank of Major in the Michigan Army National Guards. He is currently assigned to the Michigan Military Academy, Augusta.

. . .**James K. Piper, MD,** Southfield, was named Patient Education Committee Chairman of the Scientific Advisory Board of the Michigan Chapter National Foundation for Ileitis and Colitis. . . .**Lowell Butman, DVM, MD,** Frankenmuth, recently was elected president of the Saginaw County Medical Society. . . .**Patrick Beecher, MD,** Lansing, recently was re-elected to the board of trustees of Michigan Mid-South Health Systems Agency.

. . .**Margaret C. Woodbury, MD,** assistant dean of student and minority affairs and assistant professor of internal medicine at the University of Michigan Medical School, has been appointed to a five-year term on the board of trustees of Mount Holyoke College in Massachusetts. . . .**George D. Zuidema, MD,** Ann Arbor, vice provost of Medical Affiars at the University of Michigan, recently was named to the William Beaumont Hospital board of trustees. . . .Congratulations are in order for **George A. Dean, MD,** Southfield; **Harold F. Kendrick, MD,** Pontiac; **Gary E. Ruoff, MD,** Kalamazoo; and **Charles R. Zimont, MD,** Constantine, who have been appointed recently to serve on American Academy of Family Physicians committees/commissions.

. . .**Chaim Brickman, MD,** Southfield, director of immunology at Sinai Hospital, is researching familial Mediterranean fever, an elusive illness which affects the Sephardic Jewish, Chaldean, Armenian and Arab popuations in melting pot cities such as Southfield. . . .**Thomas J. Keenan, MD,** Muskegon, **Ralph G. Ryan, III, MD,** Muskegon, and **Frederick B. Brown, MD,** Muskegon, were recently appointed to the board of trustees for Mercy Hospital.

. . .**Paul D. Croissant, MD,** Bloomfield Hills, was recently elected chairman of the newly-formed Joint Council of State Neurosurgical Societies.

. . .**Michael C. Kozonis, MD,** and **Raymond A. Gagliardi, MD,** both of Pontiac, were presented with Distinguished Service Awards by St. Joseph Mercy Hospital's Boosters Club. The physicians were honored for their leadership and loyal support. . . .**John A. Rupke, MD,** of Grand Rapids, will be one of 11 employed physicians appointed by the AMA Board of Trustees to plan the June National Forum for Employed Physicians in Chicago.☐

PHYSICIAN
Directorship

Seeking qualified Physician, preferably with interest and experience in Emergency Medicine/Urgent Care, to assume directorship of an Urgent Care Center located in a town of 8000 near a large metropolitan area. Candidates must be board certified or eligible, and committed to quality patient care. Desirable characteristics include leadership ability, the ability to work with the community and its medical staff, good management skills, and progressive thinking. Responsibilities also include providing direct patient care in the Urgent Care Center. Salary competitive with excellent benefits. Send resume to: **BOX 1185.**

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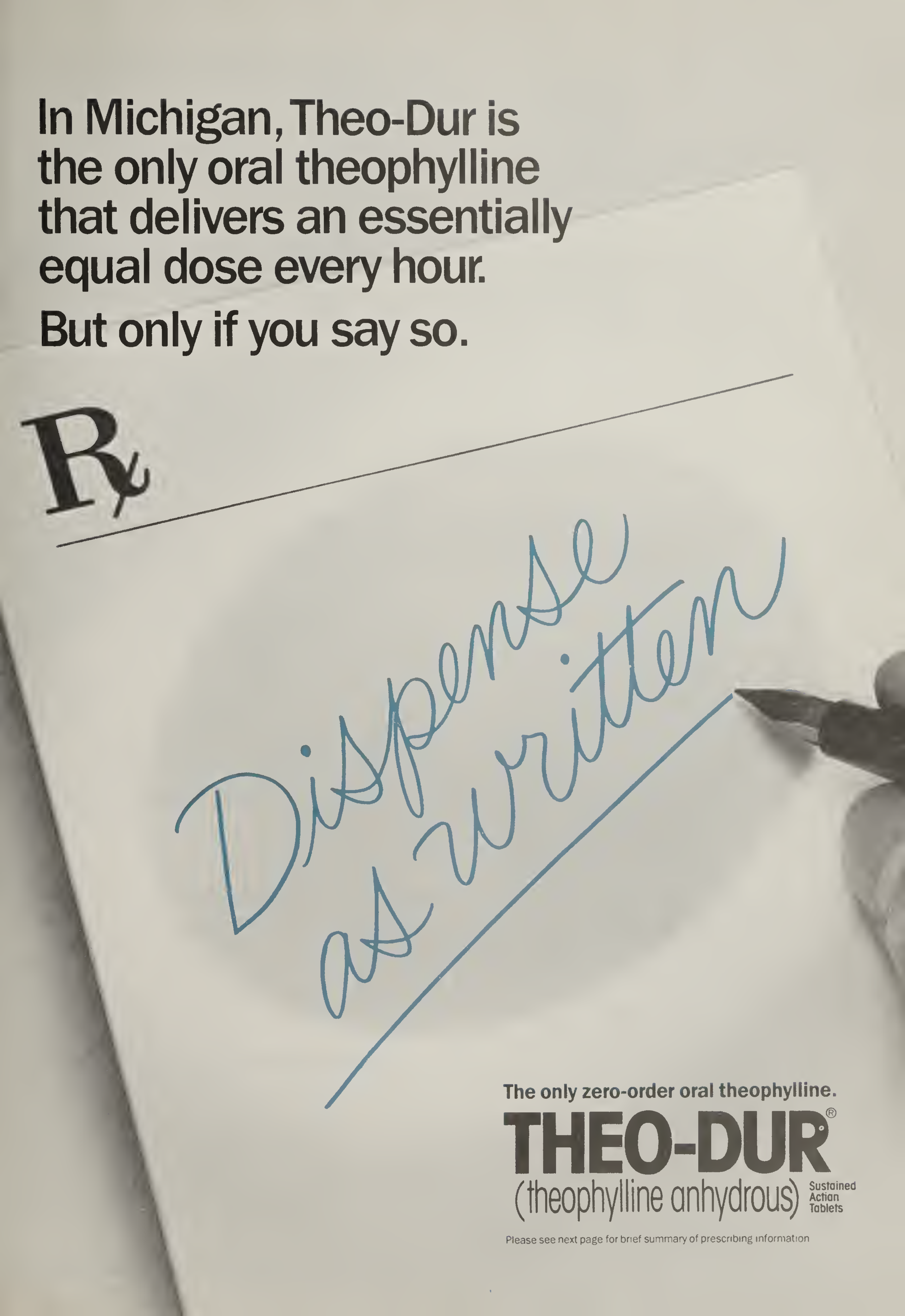
ATTN: Lois Lyons

"Buckle-up" law is one year old

. . . and the key people involved were so excited they celebrated — twice. Robert D. Burton, MD, chairman of the Michigan Coalition for Safety Belt Use, accepted a plaque commemorating the one year anniversary of the Governor's signing of the mandatory seat belt law.

Burton accepted the plaque from Secretary of State Richard Austin in an informal ceremony at MSMS headquarters, right. Formal presentation of the plaque took place at the state capitol, below. Austin and State Police Chief Col. Gerald Hough, far right, look on as Governor Blanchard congratulates Doctor Burton on the seat belt law, Public Act I of 1985. Coalition officials estimate that road fatalities were reduced by 20.3 percent in the first three months the law was in use.



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Please see next page for brief summary of prescribing information

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Description: THEO-DUR sustained action tablets contain anhydrous theophylline, a bronchodilator, in a sustained release formulation (with no color additives) which allows a 12-hour dosing interval for a majority of patients and a 24-hour dosing interval for selected patients.
Clinical Pharmacology: Theophylline directly relaxes the smooth muscle of the bronchial airways and pulmonary blood vessels, thus acting mainly as a bronchodilator and smooth muscle relaxant. The drug also produces other actions typical of the xanthine derivatives: coronary vasodilator, cardiac stimulant, diuretic, cerebral stimulant, and skeletal muscle stimulant. The actions of theophylline may be mediated through inhibition of phosphodiesterase and a resultant increase in intracellular cyclic AMP. Apparently, no development of tolerance occurs with chronic use of theophylline.
Indications: THEO-DUR is indicated for relief and/or prevention of symptoms of bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.
Contraindications: THEO-DUR is contraindicated in individuals who have shown hypersensitivity to theophylline or any of the tablet components.
Warnings: Excessive theophylline doses may be associated with toxicity; serum theophylline levels should be monitored to insure maximum benefit with minimum risk. Incidence of toxicity increases at serum levels greater than 20 mcg/ml. High blood levels of theophylline resulting from conventional doses are correlated with clinical manifestation of toxicity in: patients with lowered body plasma clearances, patients with liver dysfunction or chronic obstructive lung disease, and patients who are older than 55 years of age, particularly males. There are often no early signs of less serious theophylline toxicity such as nausea and restlessness, which may occur in up to 50% of patients prior to onset of convulsions. Ventricular arrhythmias or seizures may be the first signs of toxicity. Many patients who have higher theophylline levels exhibit tachycardia Theophylline products may worsen pre-existing arrhythmias.
Precautions: THEO-DUR TABLETS SHOULD NOT BE CHEWED OR CRUSHED. Theophylline should not be administered concurrently with other xanthine medications. Use with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, in the elderly (especially males) and in neonates. In particular, great caution should be used in giving theophylline to patients with congestive heart failure. Frequently, such patients have markedly prolonged theophylline serum levels with theophylline persisting in serum for long periods following discontinuation of the drug Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to the G.I. tract although gastrointestinal symptoms are more commonly centrally mediated and associated with serum drug concentrations over 20 mcg/ml.
Individuals who are rapid metabolizers of theophylline, such as the young, smokers, and some non-smoking adults, may not be suitable candidates for once-daily dosing These individuals will generally need to be dosed at 12 hourly or sometimes 8 hourly intervals. Such patients may exhibit symptoms of bronchospasm near the end of a dosing interval, or may have wider peak-to-trough differences than desired.
Usage in Pregnancy: Animal reproduction studies have not been conducted with theophylline. It is not known whether theophylline can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity Xanthines should be given to a pregnant woman only if clearly needed
Nursing Mothers: It has been reported that theophylline distributes readily into breast milk and may cause adverse effects in the infant. Caution must be used if prescribing xanthines to a mother who is nursing, taking into account the risk-benefit of this therapy.
Pediatric Use: Safety and effectiveness of THEO-DUR administered every 24 hours in children under 12 years of age, and every 12 hours in children under 6 years of age, have not been established.
Adverse Reactions: The most consistent adverse reactions are usually due to overdose and are:

Gastrointestinal: nausea, vomiting, epigastric pain, hematemesis, diarrhea.

Central nervous system: headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions.

Cardiovascular: palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias.

Respiratory: tachypnea.

Renal: albuminuria, increased excretion of renal tubular and red blood cells, potentiation of diuresis.

Others: rash, hyperglycemia and inappropriate ADH syndrome.
How Supplied: THEO-DUR 100 mg, 200 mg and 300 mg sustained action tablets are available in bottles of 100, 500, 1000 and 5000, and in unit dose packages of 100.
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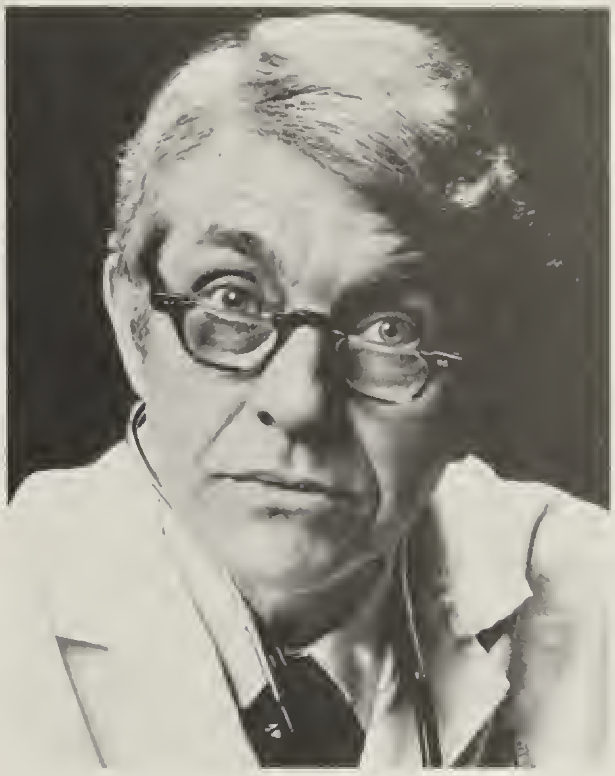

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By Carole Eberly

Rep. Lew Dodak discusses liability tort reform

Lew Dodak, the House Democratic floor leader, is a man who likes to run 10 miles a day. And it's a good thing.

Because as chairman of the House Special Committee on Liability Insurance, he is a man everyone is chasing these days—particularly because of his support—and lack of support—of controversial items in the whole malpractice area.

"I've taken the heat on this, believe me," he said. "Doctors are not very happy with this. Insurance companies aren't very happy. Attorneys are not very happy.

"So that makes me think it can't be all bad," he joked, revealing a sense of humor which allows him to keep his hectic life and legislative schedule in perspective. "Everyone seems to have problems with this package."

Physicians, lawyers and insurance lobbyists are all buttonholing him to get their points of view across while he works to solve the liability problems with physicians, bar owners and governmental units.

"We were charged with looking specifically at the availability and cost of insurance," he said. "I think the most important part of the (House) package, is the availability, although, of course, cost is important too."

With that viewpoint, Dodak has refused to back a $250,000 cap on liability awards.

"Part of my concern with the cap issue is that the cap could end up being the floor," he said. "In other words, suits that would ordinarily be filed for $10,000 would then be filed for $250,000 because we put it into the statute."

Another major reason Dodak has trouble supporting the cap approach is "we never got any real information or data from any organized group of insurers saying caps would really make a difference in the rates.

"They say down the road it could make an impact," he added. "Well, down the road tort reform will have an impact."

Dodak said the House passed a number of tort reform measures in lieu of supporting the cap.

Not the enemy

"I've told individual doctors and their organizations that I'm not their enemy by any means," he explained. "I *want* to see doctors in this state. I don't want to see us drive them out with the unavailability and/or cost issue.

"I have selfish reasons for this," he continued. "My family uses a physician. My constituents do. They're an invaluable part of our society."

However, he also said, he believes malpractice does occur. And in conferences with physicians across the state, he said, "they agree there is a problem and there has been a problem.

"We're trying to get at the source of the problem through the regulatory provisions in the package."

As part of making sure malpractice insurance is available, the House provisions call for a considerably beefed-up role for the state in the insurance area.

"Some are happy, some are not," he said. "But if we want availability, we want to make sure a doctor can get coverage. We have to have a mechanism to do that.

"I don't want to have to get into the insurance industry," he continued. "I don't think the state wants to get into it. But in this particular case, I think we have no choice.

"My main concern is I don't want to see us force out the good doctors, and end up with a few that may not be as good as the ones who are leaving," he added. "This is a real concern."

He emphasized that "tort reform is going to happen." "It is not going to be a cure-all overnight," he said. "It will have a long-term impact. Insurance companies are going

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Ms. Eberly is a Lansing-area freelance writer.

to see it in one or two years, and hopefully, pass these savings along. That's why even the cap would not have cured the availability problem in this state as of April 1. And, there were a lot of doctors being cancelled by that date."

Although Dodak, after serving ten years in the House, seems comfortable and unruffled in his role as heat-taker, he is quick to point out the legislature did not create the malpractice situation.

"We've been dragged into it and we're caught right in the middle," he said. "It's frustrating for us because we're not experts in the medical area, most of us are not experts in the legal area. But we're doing the best we can.

"We don't want to lose our doctors," he added. "But we also want to make sure that when there's a victim out there, he or she has some rights in this process as well."

How much contact does Dodak have with physicians?

He smiles when he explains that his family physician, Lowell Butman, MD, is president of Saginaw County Medical Society.

But while Dodak is on the hot seat, he resists the temptation to work endlessly on malpractice. He commutes almost daily the 120 miles between Lansing and his home in Montrose. He is home on the weekends, reserving Sunday exclusively for his family.

A Vietnam veteran, he has strayed little from his farm where he grew up in the southern part of Saginaw County. His younger brother now runs the family corn and bean farm.

During summer sessions, Dodak has been known to tow along one or more of his three children to follow him around the Capitol. With two boys, Tony, 16, and Aaron, 11, and one daughter, Christina, 5, he gets different perspectives on the legislature from them all.

Will any of the little Dodaks follow in their father's footsteps?

"I don't know if I'd want to see any of them get into politics," he said. "That's not to say I haven't enjoyed it. But your time is not your own. You truly have to like people. I've loved being in the legislature. It's the type of job that when I get up in the morning, I know the day's going to be different than the previous one. I'm going to meet new people. It's going to be challenging. I may get frustrated before the day's over.

"But I've learned over the years, you can't take anything personally. I've gone to places where I've been raked over the coals when people have not seen my point of view. I always tell people, no matter what we do, half the time somebody probably doesn't agree with it. So we're always half wrong and half right."

Down the road

Even though Dodak is up to his ears with administrative duties in his post as floor leader, *besides* serving on committees, and even though there are only 24 hours in a day, and even though he is on the hot seat, does he want more?

His immediate goal, he said, is to win re-election to his House seat and be re-elected by his colleagues to his House leadership post. Beyond that?

"Obviously, down the road, you never say never," he said. "If a congressional seat opens up, I would definitely consider it. People in politics traditionally are ambitious people. We have a tendency to want to do other things."

Would that include being Speaker of the House, if that position became available?

"That would be the ultimate in a House career, no doubt about it," he said.

But, one thing is certain: Dodak will never put his running shoes away. It's up to the others to keep up with him.☐

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By Willard S. Stawski, MD

Tort reform 1975 to 1985 — a decade of progress?

A decade ago Michigan citizens faced a crisis involving medical liability. This crisis was widely viewed as an argument between attorneys and physicians over fees. Some physicians, however, could not obtain liability insurance at any cost. To remedy this crisis, several steps were taken including the establishment of arbitration panels, a state liability insurance fund, and limitation on contingency fees. In 1975, the Michigan Supreme Court was concerned that high jury awards were sending medical malpractice rates skyrocketing and making insurance difficult for doctors to obtain. For example, in 1975, an attorney would receive $183,333 or $165,250, depending upon the schedule, for a $1 million plaintiff's award. The Supreme Court later revised this limitation and increased it to one third of the damages so that the attorney could receive $333,333 of a $1 million award. This revision was heavily supported by the State Bar of Michigan.

Since 1975, the Supreme Court's concerns about high jury awards have been ostentatiously demonstrated, inviting critical comment from attorneys themselves.

Attorney Grant P. DuBois, Chairman of the National Coalition for Litigation Cost Containment has written, "The Coalition agrees that contingency fees serve a useful social purpose in enabling persons with limited means to seek redress in our courts. However, the volume of tort litigation and the explosion in the size of awards have resulted in grossly disproportionate compensation to the plaintiff's attorneys. The present system simply provides an incentive to plaintiff's attorneys to pursue atronomical judgments, resulting in the encouragement of insubstantial suits, the clogging of the court system, the bankrupting of businesses, and the inability of insurers to provide desired coverage for businesses, professional services, government entities and indeed, ultimately, anyone liable to incur a tort."

Professor Jeffrey O'Connell, a law professor at the University of Virginia, puts it more succinctly: "Lawyers have made an unholy mess of the medical malpractice system." Professor O'Connell proposes a no-fault system similar to Michigan's no-fault auto insurance as a significant tort reform.

The editor of the United States Automobile Association Magazine *Aide* writes, "Clearly, our civil justice system is in a crisis. In the minds of many, it is fraught with unnecessary lawsuits, skyrocketing costs, long delays and unpredictable results. Last year, one private civil lawsuit was filed for every 15 Americans, and jury verdict awards of $1 million or more totaled 360, almost one a day."

And in fact, US Attorney General Edwin Meese commented while addressing the California Bar Association in 1985, "If this trend toward massive increases in punitive and non-economic damages continues, the impact on our nation's economy will be devastating. Both the size and

Continued on page 180

Doctor Stawski is a Grand Rapids general surgeon.

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unpredictability of these awards threaten to suppress the commercial vitality upon which our free society so desperately depends. It will have...a 'chilling effect' on industry, in particular, and business generally.''

A lopsided system

Since virtually no action was taken to substantially reform the tort system in Michigan a decade ago, it should come as no surprise to anyone that this flagrantly lopsided, oppressive, costly system remains as the defective cornerstone of our civil justice system.

Civil liability justice reform measures have been introduced in Congress and in all of the states. Many individual bills, dealing with liability reform, have been introduced into the Michigan legislature and have been passed by either the House or the Senate; it is distressing that no agreement on these bills has yet been reached, no bills have passed both houses, no bills have been signed by the governor, and no new legislation has been enacted.

As the inequities of this flawed system affect business, municipalities, government agencies, day care centers, restaurants, bowling alleys, architects, CPAs and the legal system itself, a rising chorus of voices is heard demanding that major changes be made in the tort system.

The cover of *Nation's Business* featured this quote in its February, 1986 issue. ''The liability insurance crisis is the most serious threat to business today. Companies risk bankruptcy by paying soaring premiums or going without insurance. The results include lost jobs and higher prices. Experts blame a litigation explosion in which there is a private civil lawsuit for every 15 Americans. Many of those suing count on a trend of fat awards that assume wrongdoing by business.''

And as individuals are richly rewarded for their irresponsibility, a small segment of society is charged their bill. An overweight man with heart disease sustains a heart attack while attempting to start his lawnmower and is awarded $1 million by the jury because the starter rope required excessive effort.

A motorcyclist is injured when he rams a parked truck and sues the truck's owner. A mediation board, citing the motorcyclist's own role in the accident, limits a damage award to $20,000 dollars. The case goes to a jury which increases the award to $4.2 million.

> **"...a rising chorus of voices is heard demanding that major changes be made in the tort system."**

Perhaps the most ironic feature of medical liability is that lawsuits don't stop bad doctors. Dolly Katz, a medical writer for the *Detroit Free Press* writes, ''Malpractice lawsuits, despite their popularity, their numbers and the apprehension they instill in medical circles, do not protect the public from bad doctors.

''They do not separate the good doctors from the bad.

''They compensate only a fraction of patients injured by negligence. And they do not drive bad doctors out of business. Doctors who are sued so many times that they can't get coverage simply practice without insurance.''

The unreasonable must be made reasonable once again. Perhaps an anecdote recalled by David C. Sabistan, Jr., MD, in the *Bulletin of the American College of Surgeons* of 1985 is instructive. He recounts the story of two physicians who were sued by a plaintiff who had sustained a fractured leg and who had engaged the physicians to set the bone. The break was a bad one, and the healing process was slow and when completed, as not to be unexpected in an elderly patient, a slight shortening of the limb occured. The plaintiff felt that the two surgeons had not given the fracture proper attention and sued them for malpractice.

The attorney who defended the two physicians used a chicken bone to explain the different conditions in the bones of young people compared to those of advanced age. He stressed the fact that the bone of a young person has a springy, wiry condition that makes it less apt to break and that it has a tendency to knit quickly. In the case of older individuals, however, the attorney noted that the bone is more brittle because lime and other qualities impair the healing process.

In his reasonable and succinct summary, the attorney states, ''Mr. Fleming, instead of bringing suit against these surgeons for not giving your bone proper attention, you should go on your knees and thank God and them that you have your leg. Most other practitioners with such a break would have insisted upon amputation. In your case they exercised their skill and ability to preserve it and did so. The slight defect that finally resulted, through nature's method of aiding the work of the surgeons, is nothing compared to the loss of the limb altogether.''

The year of this suit was 1856, and the attorney was Abraham Lincoln!☐

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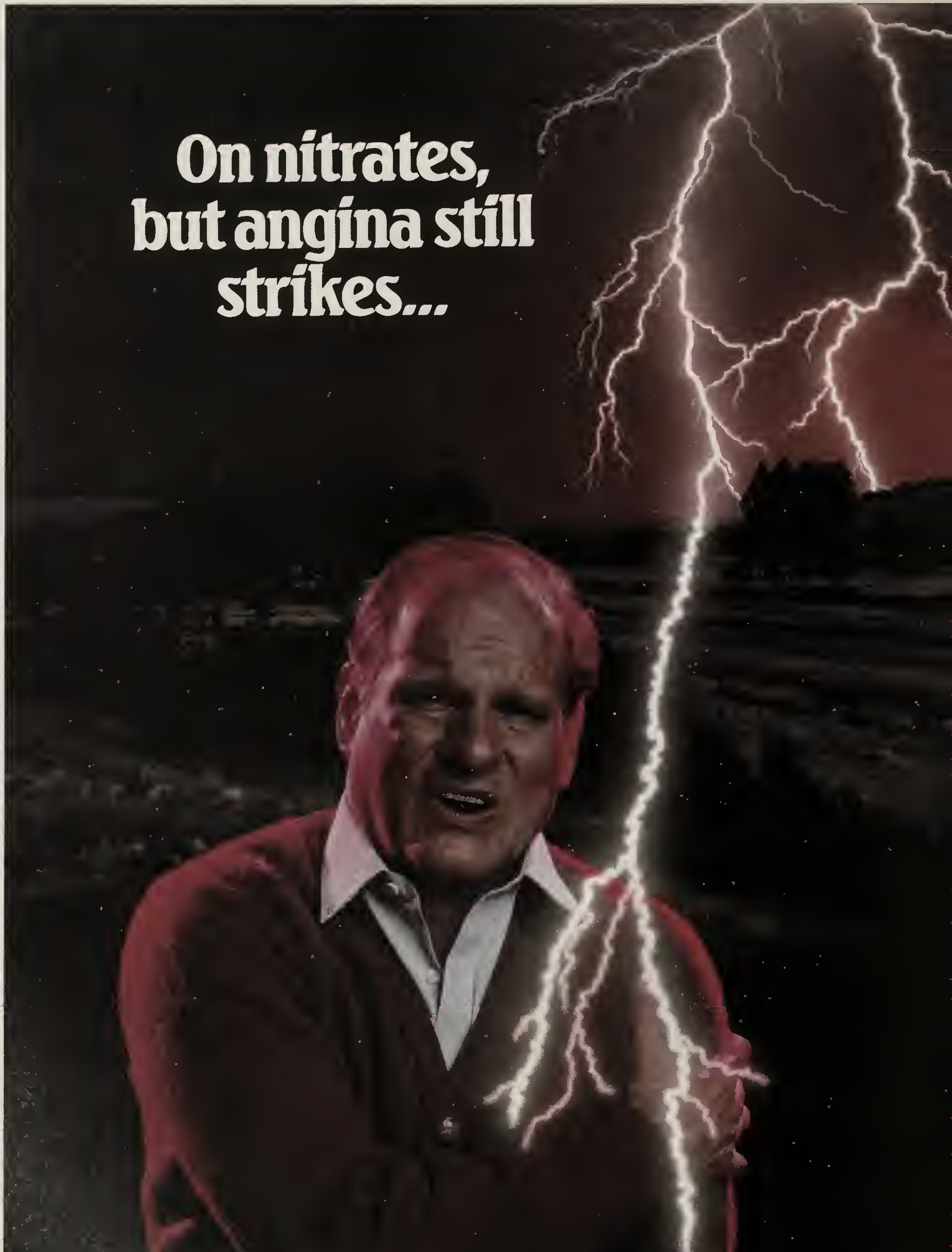
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Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. 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One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. 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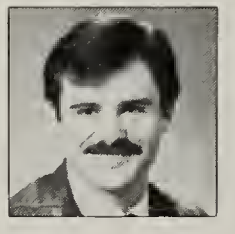

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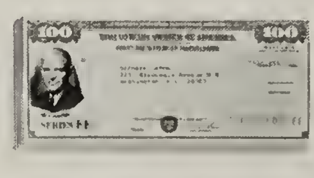

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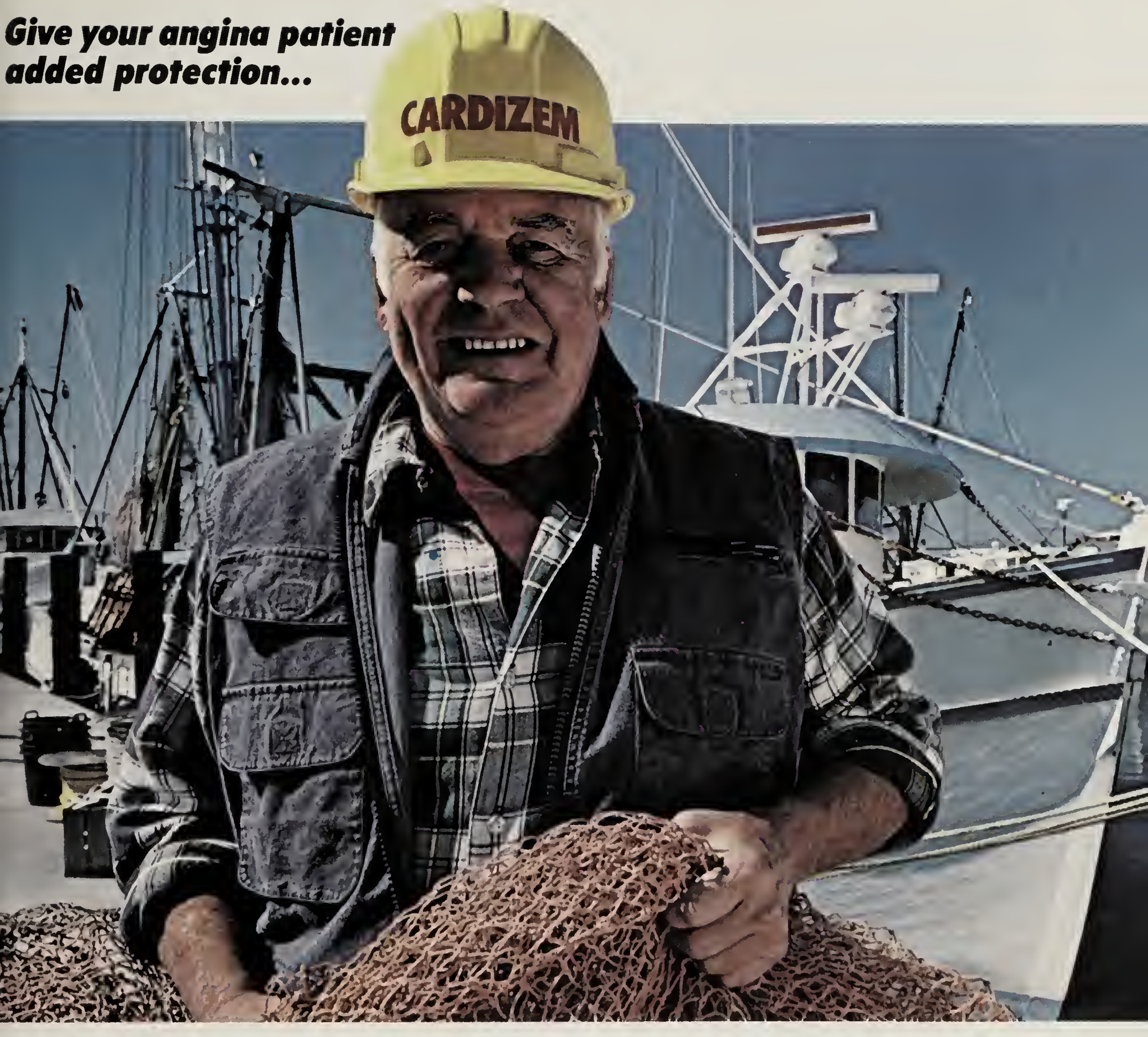

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FEWER SIDE EFFECTS IN ANTIANGINAL THERAPY

BRIEF SUMMARY

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist).

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1 **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.

2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited Caution should be exercised when using the drug in such patients

3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.

4 **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM (diltiazem hydrochloride) in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System.	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity
Other.	Polyuria, nocturia.

The following additional experiences have been noted

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM. erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered

Bradycardia	Administer atropine (0.60 to 1 0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy
2. **Prophylactic Nitrate Therapy** — CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

CARDIZEM 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other. Issued 4/1/84

See complete Professional Use Information before prescribing

0642T5

References: 1. *Physicians' Desk Reference*®, ed 39. Oradell, NJ, Medical Economics Company Inc, 1985. 2. Cohn PF, Braunwald E. Chronic ischemic heart disease, in Braunwald E (ed): *Heart Disease: A Textbook of Cardiovascular Medicine*, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39. 3. Schroeder JS. Calcium and beta blockers in ischemic heart disease. When to use which. *Mod Med* 1982; 50(Sept) 94-116. 4. Subramanian VB. Comparative evaluation of four calcium antagonists and propranolol with placebo in patients with chronic stable angina. *Cardiovasc Rev Rep* 1984; 5:91-104 5. Schroeder JS, Feldman RL, Giles TD, et al Multiclinic controlled trial of diltiazem for Prinzmetal's angina. *Am J Med* 1982; 72:227-231 6. Weiner DA, McCabe CH, Cutler SS, et al: The efficacy and safety of high-dose verapamil and diltiazem in the long-term treatment of stable exertional angina. *Clin Cardiol* 1985; 7:648-653. 7. Shapiro W Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. *Consultant* 1984; 24(Dec):150-159.

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By Sheri Greenhoe
Managing Editor

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eject components not up to our standards.

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The body is of a special carbon-fiberglass omposite developed by Lotus. It *can't* rust.

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This 16-valve, 4-cylinder mid-engine dynamo will take you from 0 to 150 faster than a prudent man would care to do it.

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A computerized fuel metering system is now also part of the power plant. It virtually *anticipates* split-second power needs. And improves gas mileage, giving the car a touring range of over 500 miles.

And to give you more of the open road while you're out there, a totally integrated, removable roof panel is now standard on every Turbo Esprit.

We also made refinements in the turbocharger, suspension, brakes and tires to keep the car in tune with its new power.

The Esprit is now as close to perfect pitch –power, precision, predictability working in unison–as a car is likely to get.

"It puts me at one with the road as no car ever has," is how one enthusiast summed it up.

He also commented on feeling secure in the car because it is very forgiving and "...always has something in reserve."

But that's another whole story....

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Lotus

By Alfred B. Swanson, MD, FACS

Citizens' Liability Action Committee proposes limiting contingency fees

A group of citizens concerned about the liabilty crisis met in December, 1985 in Grand Rapids and formed an organization which they named "The Citizens' Liability Action Committee." The group consisted of community leaders who serve the public and who have become alarmed at the epidemic of civil lawsuits which has, in effect, increased the cost of liability insurance to staggering heights, making it difficult, if not impossible, to continue in business.

A number of approaches and proposals were considered to alter and improve the laws of the State of Michigan along the lines of what other states have successfully enacted. It was felt that the best method for this committee's activities would be to use the democratic option, which is available in our state through a citizens' initiative, to have a referendum placed on the ballot for voting by the public in November, 1986.

It was suggested that only one issue should be considered and that it should be a solution which is acceptable as meaningful for tort reform and also a solution that is not being considered by the legislators or the Governor.

After discussion with many legislators, professionals of national stature and attorneys, it was felt that the solution could be in limiting the contingency fee similarly to what has been proposed in the federal malpractice legislation introduced by Senator Orrin Hatch (R-Utah). We were told by Michigan legislators that they would not be considering any bill on limitation of attorneys' fees and they encouraged us to go ahead with the initiative. We, therefore, have sought and received approval to offer a proposed amendment to the Constitution of the State of Michigan.

Because of the broad representation of the membership of the committee, the proposal will not address just cases of malpractice, but rather any personal injury or wrongful death. To place the proposal on the November, 1986 ballot, 304,000 petition signatures are needed. The proposal is noted here:

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Doctor Swanson is director of hand and orthopedic surgery training programs at the Grand Rapids hospitals, professor of surgery at Michigan State University, and director of orthopedic research at Blodgett Memorial Medical Center, Grand Rapids.

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The proposed amendment Article VI, Section 5

Article VI of the Michigan Constitution of 1963 is hereby amended by replacing Section 5 with a new Section 5 to read as follows:

"Section 5. The Supreme Court shall by general rules establish, modify, amend and simplify the practice and procedure in all courts of this state. Notwithstanding any such general rule, however, no attorneys shall accept for legal services rendered to any claimant in connection with any personal injury or wrongful death claim or action any fee contingent in whole or in part on the disposition of said claim or action which exceeds the lesser of: (a) ⅓ of the first $200,000 recovered and 5 percent of any amount over $200,000 recovered; or (b) the amount agreed upon between the attorneys and clients as fees for services.

The court's rules shall, as far as practicable, abolish the distinctions between law and equity proceedings. The office of Master in Chancery is prohibited."

Provision of existing Constitution altered or abrogated by this amendment if adopted Article VI, Section 5

"Section 5. The Supreme Court shall by general rules establish, modify, amend and simplify the practice and procedure in all courts of this state. The distinctions between law and equity proceedings shall, as far as practicable, be abolished. The office of Master in Chancery is prohibited."

We are attempting to enlist circulators from all organizations willing to secure voter signatures on the petitions. It will require an all-out effort if these signatures are to be obtained in the short time remaining to the July deadline.

The problem

Almost everyone agrees that there is now a true liability crisis in the United States, not only affecting health care professionals, but also institutions, businesses, manufacturers, municipalities, retailers, restaurants, bars, engineers, architects, contractors, owners of recreational facilities, schools, day-care centers, property owners, churches, public buildings—this is almost anyone who produces a product or provides a service to the public.

"At the present time the litigation problems in Michigan remain the worst in the country."

In this most recent litigation explosion, it is stated that there is a private civil lawsuit for every fifteen Americans. Almost every doctor can look forward to at least one malpractice suit in his career. Companies risk bankruptcy by paying soaring premiums or "going bare" without insurance. This is considered the most serious threat to business today. The results include lost jobs and higher prices. Experts blame a legal system that encourages litigation and allows huge jury awards. There are three times as many lawyers as there were in the 1950s and it costs 37 times more to run the tort system that it did then.

The Governor and Legislature are trying to control the problem with a patchwork of laws which in some instances may be useful. There are laws in effect in other states and in other countries which have reasonably controlled this type of litigation. We would strongly recommend that our governmental representatives research the successful works of others. At the present time the litigation problems in Michigan remain the worst in the country.

Not eliminating the fee

The contingency fee arrangement as practiced in the United States is not allowed in any other country. There is no question that it acts as an incentive for suing both by the plaintiff and the attorney. It is about time Americans took a look at this system.

The fact that the contingent fee is the spearhead of this committee's efforts does not mean that the contingent fee should be totally eliminated (though many experts in the field think it should be). Our proposal is to front load the contingent fee with a higher percentage for the lawyer up to a reasonable amount, and then restrict the fee thereafter on the basis that if the plaintiff deserves a larger award, that money should go to him and not his attorney as a bonus for his "enthusiastic pursuit of the case." Most agree that one-third of $200,000 after expenses is appropriate for the time involved in the majority of cases. At the present time attorneys can charge, in addition to their expenses, one-third of an award no matter how large it is. We wonder what they would say if doctors charged one-third of a patient's life earnings if we save his life or put him on his feet?

The original concept of the contingency fee was, indeed, justified as the "poor man's key to the courthouse," but that concept has been unabashedly abused in recent practice. It has been shown

Continued on page 194

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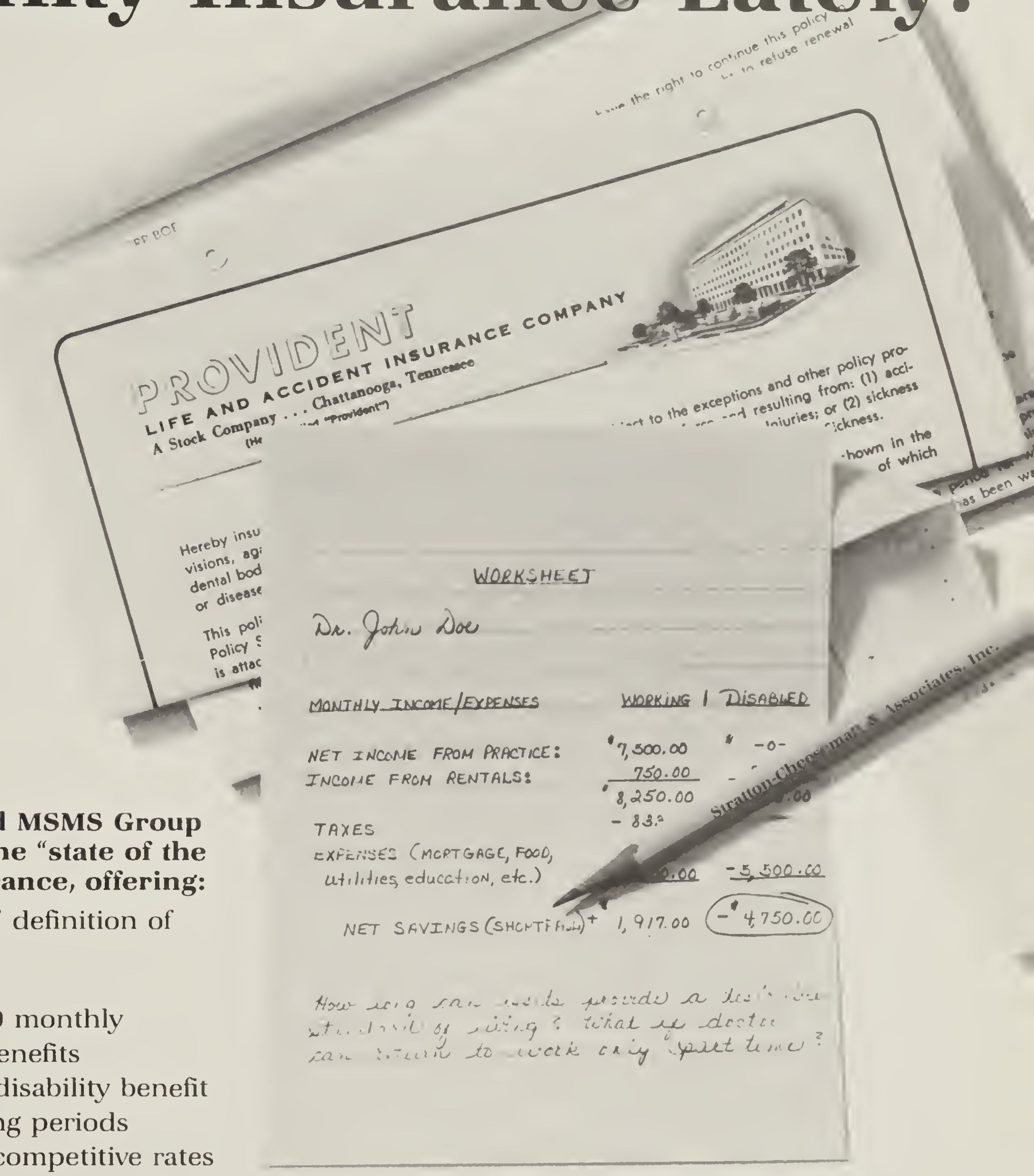
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that the patient receives as little as 21 cents of the liability premium dollar. The so-called transaction costs of the system, such as legal fees and administrative processing, make up as much as 70 percent of the dollar and the rest goes for overhead of the insurance companies.

Someone in the law profession will have to recognize and admit that the story of the liability crisis is really the story of an entire legal system in crisis. Society is beginning to recognize this, and unless the law profession takes steps to correct it in the public interest, society will surely do it for them. Everyone admits that there is an enormously increasing number of suits being filed, that there is a wide disparity in jury verdicts for the same type of case, that there is no social utility for punitive damages or assigning dollars for grief. The tort system increases the cost of legal services enormously and has a secondary effect in which the public is paying a lot of money to protect itself against a few people. The public wants the best possible medicine for the best possible price and as they also want to have the best buy for the products they use, they also want the best legal aid for the best possible price.

We are confident that the majority of attorneys in the noble and honored law profession who work on a proper fee for service basis do not really support those in their profession who would bargain for a portion of a client's award to ensure "enthusiastic legal representation."

The insurance industry, with all of its problems, has failed, with few exceptions, to represent both physicians and the public. Its immediate and sole response seems to be to multiply premiums to exorbitant rates. Instead of proposing solutions when the going gets hot, the industry turns and runs. Again, society is the victim of the system. Insurance premiums have become a lead weight around the neck of those who could provide progress to our communities. This is a symptom of a serious public disease which demans everyone's concern and action.

The medical care problem

Why has the liability crisis descended on our society like a devastating storm? Medical care is actually better now than at any time in our history. The medical profession has in the last 50 years increased life expectancy by one-half, it has eradicated plagues and epidemics and has controlled infectious diseases. It has redefined the role of the hospital from a place to die into a place to live. It has improved the chances of surviving illnesses which before were hopeless.

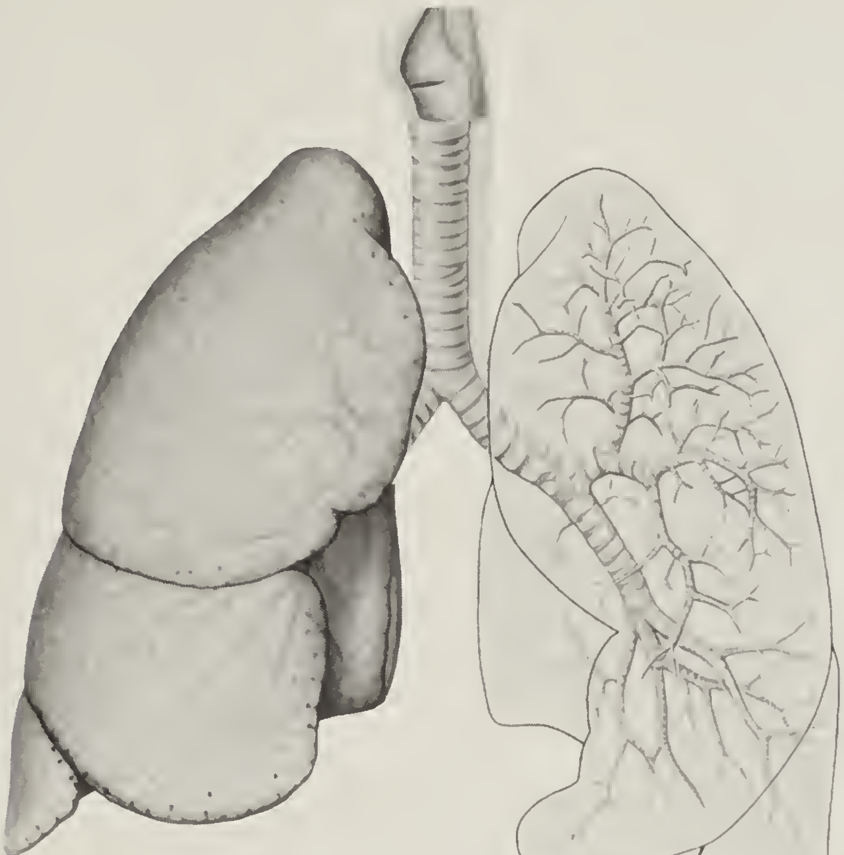
How can this tremendous effort be found to be not good enough? Why must a doctor, all of a sudden, be the guarantor of the health of every person he sees? It isn't a question of suddenly discovering a bunch of bad doctors treating good people badly in bad hospitals. It is rather, that bad laws are being interpreted and promoted by a small group of bad lawyers. There is of a new consumerism attitude by some people who think that every adversity in life is someone else's fault and must be paid for. Unfortunately, doctors are constantly exposed to these people and their adversities and become sitting ducks to their avarice.

The people of Michigan have an opportunity to save their excellent health care delivery system before it becomes immobilized because doctors and hospitals cannot afford to pay the outrageously high liability premiums when they *can*, in fact, get insurance coverage. In other parts of the country doctors have gone on strike, retired or moved, and that will occur here unless we fight to preserve our medical care delivery system because we believe in it.

If the people approve our proposal in November, it would become the law of the State of Michigan and would not require the action of the Governor or the Legislature. It should be noted that similar proposals have passed Supreme Court muster. This proposal not only will go a long way in controlling the liability problem, but will also act as leverage to have meaningful laws passed by the legislature.

The "poor man's legal fee" has become his and society's burden. The public's interest is being abused and the people are being ripped off—and they now know it. They will have their chance to put balance back in the situation at the November, 1986 election if the necessary 304,000 signatures are obtained. The Citizens' Liability Action Committee is trying to set a "grass roots" campaign going by mobilizing all segments of the community. It is simply a question of the logistics of presenting the problem to the people. They appear willing to make this decision. We need, and ask, your help.☐

Note: MSMS leadership has decided not to take a stance on this proposal because it is a private citizens' initiative. This article was published out of courtesy to Doctor Swanson who has long been an active member of Michigan State Medical Society.



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Brief Summary Consult the package literature for prescribing information

Indications and Usage Ceclor® (cefaclor Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae* and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication. Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS INCLUDING ANAPHYLAXIS TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile* Other causes of colitis should be ruled out

Precautions: *General Precautions* – If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued and if necessary, the patient should be treated with appropriate agents, e g , pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease particularly colitis

Usage in Pregnancy – Pregnancy Category B – Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor® (cefaclor, Lilly) There are, however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers – Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0 18, 0 20, 0 21, and 0 16 mcg/ml at two, three, four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children – Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain – Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic – Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic – Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal – Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[061782R]

Note Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

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Additional information available to the profession on request from
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Carolina Puerto Rico 00630

Reye's Syndrome update

The first case of Reye's Syndrome since April, 1985, has been reported in Michigan. A six-year-old female from Gratiot County developed symptoms of Reye's Syndrome after experiencing a respiratory illness.

Since the last update memo influenza B has been isolated from Lenawee County and influenza A has been isolated from Kalamazoo, Calhoun and Ingham Counties. For the week (ending February 14) 45, 119 Michigan school children were reported absent with influenza-like illness. This figure is almost double the count for the week ending February 7.

The Center for Disease Control has determined that influenza B, isolated from Ann Arbor this winter, had undergone antigenic drift from the B/USSR/100/83 used in this year's vaccine.

Cookbook to lower cancer risk

It was Benjamin Franklin who once wrote that "an ounce of prevention is worth a pound of cure." That's exactly the message behind a new cookbook to lower cancer risk just published by the American Institute for Cancer Research (AICR), a national non-profit organization which has focused on cancer prevention through diet and nutrition. Entitled *An Ounce of Prevention*, this first volume in a four-volume series of cookbooks presents a variety of recipes meeting the Institute's dietary guidelines for lower cancer risk.

"The relationship between serious diseases, such as cancer, and the foods we eat is becoming clearer every day," noted Mariln Gentry, editor of *An Ounce of Prevention*.

The American Institute for Cancer Research emphasizes dietary guidelines that are based on the 1983 report of the National Academy of Sciences, *Diet, Nutrition and Cancer*. These guidelines call for a reduction in the amount of fat in our daily diets, increased consumption of fruits, vegetables and whole grain products, and moderation in the consumption of certain foods, such as cured or salted meats and alcohol.

An Ounce of Prevention is available from AICR for $6 per copy, which includes all handling and postage costs. Copies may be ordered by sending a check or money order for six dollars, payable to "AICR," American Institute for Cancer Research, AICR Cookbook, Dept. CB1, Washington, DC 20069.

Children and home infusion therapy

The drive to discharge patients from the hospital sooner and reduce health care costs has helped fuel the growth of home infusion therapy, which allows patients to administer their own intravenous medication at home. A new study at Henry Ford Hospital is investigating the use of home-based therapy for children with bacterial illnesses.

The program evaluates infants and children with illnesses such as osteomyelitis and bacterial pneumonia.

The study is designed to improve the quality of life for these patients while reducing health care costs, according to Edward B. Lewin, MD, project director and head of the Hospital's Division of Pediatric Infectious Disease.

Parents or caregivers are instructed how to administer medication and monitor the child's vital signs, as well as how to render care that normally is done by nurses in the hospital setting. Frequent visits are made to the home to observe care and monitor the child's progress. Children are encouraged to participate in their own care.

The study has evolved from several beliefs developed by Doctor Lewin over the years: Those individuals, usually parents, most highly motivated to care for the child should render that care; almost all non-intensive care provided by nurses can be learned and performed by parents; a hospital generally can't match the physical and psychological comforts of home; hospitalization of a child leads to significant disruption in family life; it is more expensive to render care in the hospital than at home.

Previous studies of home IV therapy generally involved adult patients past the acute stage of illness. This is one of the first studies that investigates complete home therapy for children who are still ill, but in a stable condition.

To qualify for the study, patients must live within 30 miles of a Henry Ford Hospital facility. For information contact Henry Ford Hospital (313) 876-2882.

Computer chip brain probe

Microelectronic brain probes may one day help scientists learn how to steer brain signals around damaged nerves to revive paralyzed limbs.

The technology, being pioneered at U-M, also may someday help restore sight to people with nerve-related blindness and help return hearing to people whose deafness stems from neural injury, said Ken Wise, professor of electrical engineering and computer science.

A research team led by Wise has designed a microcircuit the size of a pin head that can be inserted safely in the brain to record the individual signals of several neighboring nerve cells.

Much already has been learned about single neurons by using metal microelectrodes, usually in the form of sharpened pins. But relatively little is known about the organizations of neurons as functional circuits, Wise said.

"Now we'll be using a recorder with state-of-the-art silicon technology to open up potentially a whole new area," said Wise, whose research is funded by the National Institutes of Health (NIH). "If it's successful, it will have a major impact on the field of neurophysiology, and later on rehabilitation, letting us look at effects we've been unable to see before."

The recording of individual nerve signals in small clusters throughout the brain is expected to yield new clues to the code with which neurons communicate. Deciphering the code is one step toward developing electronics to artificially control muscle movement or sensory activity.

The chip, designed by Wise and graduate students Khalil Najefi and Ken Drake, can be implanted without injury, virtually floating in brain tissue. Each chip holds 12 recording sites and an array of electronics to amplify the nerve signals recorded by each site and combine the signals for transmission from the probe over a single thread of wire.

Limiting the number of wires tethered to the probes helps reduce the chances of a short circuit—because fewer electrical connections are required—and poses less risk of infection when implanted.

The integrated probe is being fabricatd, but U-M scientists already have tested a passive form of the probe, one that lacks the on-chip electronics.

Anesthesia and sedation in the dental office

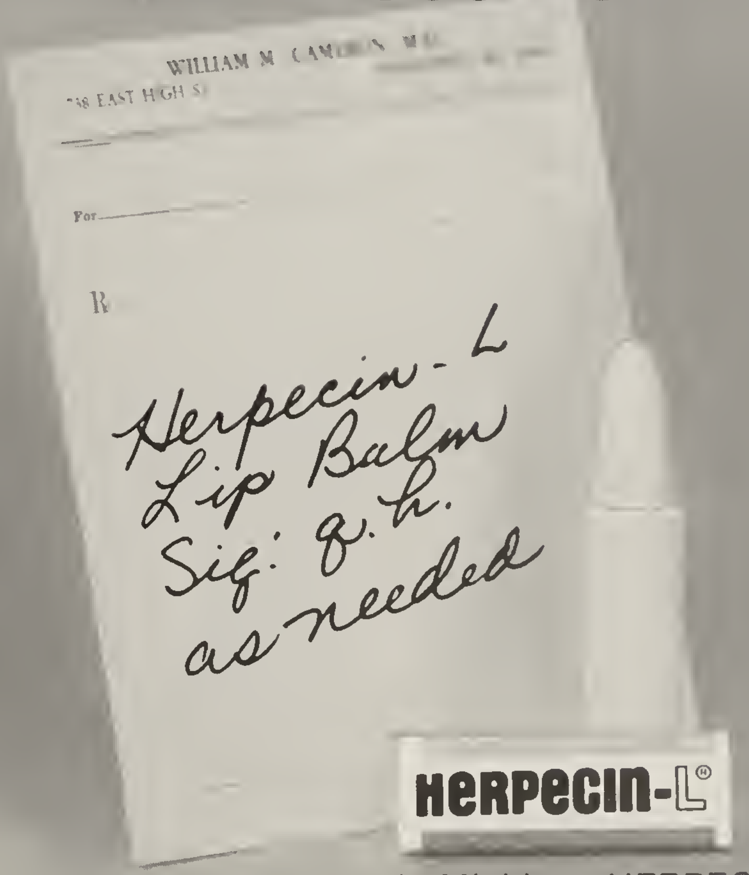
A National Institutes of Health (NIH) consensus development statement on anesthesia and sedation in the dental office now may be obtained from the NIH Office of Medical Applications of Research.

The statement was prepared by a panel of experts that considered scientific evidence presented at a consensus development conference at the NIH, and it contains recommendations and conclusions concerning anesthesia and sedation in the dental office.

At the NIH, consensus conferences bring together researchers, practicing physicians, representatives of public interest groups, consumers, and others to carry out scientific assessments of drugs,

Continued on page 198

Dx: recurrent herpes labialis



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**This course has been approved for 13 credit hours in Category 1 of the Physician's Recognition Award of the AMA.

devices, and procedures in an effort to evaluate their safety and effectiveness.

Free single copies of the consensus statement on anesthesia and sedation in the dental office are available from: Michael J. Bernstein, Office of Medical Applications of Research, National Institutes of Health, Building 1, Room 216, Bethesda, MD 20892.

ACEP calls for ban on tobacco advertising

The American College of Emergency Physicians (ACEP) has called for a total ban on tobacco advertising. Although cigarette advertising was banned from television in 1971, the cigarette industry spends more than $1 billion a year on print advertising—more than any other product.

ACEP also favors an immediate end to government subsidies to the tobacco industry. The association believes that ending these subsidies would place the tobacco farming industry into a competitive situation. This could cause tobacco prices to rise, possibly discouraging nonsmokers from starting the habit.

In additon, ACEP supports raising taxes on tobacco products and devoting the revenue to the care of patients with tobacco-use-related disease. ACEP also is encouraging the prohibition of tobacco smoking in public places, except in designated areas.

Finally, ACEP endorses continued use of honest and accurate warnings, such as package inserts, on all tobacco products, whether for domestic use or foreign export. "By providing package inserts in all tobacco products, tobacco users would be supplied with more in-depth information about the medical effects of tobacco use," said Richard L. Stennes, MD, FACEP, president of ACEP.

"ACEP believes that use of any tobacco product can be dangerous to your health," Doctor Stennes added. "If the above concepts became law, they could help to discourage nonsmokers from starting, and encourage smokers to cut down or perhaps even quit the habit."

In other action, ACEP is urging motion picture and television industries to show all passengers in motor vehicles wearing seat belts.

Thyroiditis and dietary iodine

There may be a direct link between the rising incidence of autoimmune thyroiditis in Americans and their consumption of large amounts (2 to 5 times the recommended daily allowance) of iodine. Tom Brown, MD and Nandalal Bagchi, MD of Hutzel/Wayne State recently published their research in *Science* magazine. They found that in two genetically susceptible strains of chickens, development of autoimmune thyroiditis—inflammation of the thyroid brought on by antibodies directed against the gland—varied with changes in dietary iodine.

In the strain with low incidence of mild disease, addition of iodine to the diet promoted disease; in the strain with severe disease culminating in complete destruction of the thyroid gland, blockage of uptake of iodine diminished thyroid-directed antibody responses. When iodine concentrates in the thyroid, it is incorporated into thyroglobulin molecules, altering their shape and probably increasing their immunogenicity. This may account for the enhanced production of antibody and the initiation of autoimmune disease. □

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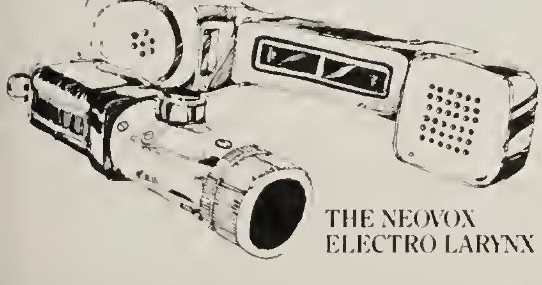
Telecommunications Quality Centers for the Handicapped. If you have handicapped patients with special communications needs, you might suggest they visit one of our Centers. They'll find a full selection of state-of-the-art communications products and services on display to assist people with hearing, speech, motion and vision impairments. There are also products and services for those who are having difficulty seeing, hearing or moving about… like many senior citizens, for example.

Help for people with vision, hearing, motion or speech problems. Just a sampling of these communications helpers include Jumbo Button* Telephones, Portable Electro Larynxes, Amplified Receiver Handsets (like these shown), Emergency Call Systems for Smoke/Fire or Medical Alert, Telecommunications Device for the Deaf (TDD) and a whole lot more.



And our Centers offer more than just products. They're staffed with experts skilled in meeting the special communications needs of people with impairments. The Center personnel are also involved with programs for the handicapped in hospitals, health seminars and social service agencies.

Here are the Center addresses and phone numbers:

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1 800 482-3141 (TDD)

☐ 1365 Cass Ave., Room 102
Detroit, MI 48226
(313) 223-8732 (Voice/TDD)

☐ 221 N. Washington
Lansing, MI 48933
1 800 525-7134 (Voice/TDD)

☐ 114 North Division
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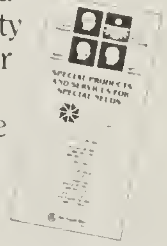
The Centers are open Monday thru Friday from 8:30 a.m. to 5 p.m.

Want more information? We have free literature including a brochure titled "Special Products and Services for Special Needs." It will acquaint you with our latest products and services. If you would like to have a quantity of these materials for distribution to your patients, just call the toll-free number of the Center in your area.



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MSMS Auxiliary Legislative Day highlights — March 13, 1986 Lansing

Louis R. Zako, MD, chairman of the MSMS Task Force on Professional Liability, had an encouraging message for the 140 Auxilians and their physician spouses that attended the all-day session at Lansing's Civic Center. MSMS/A President Cathie Martin looks on.

Paul Conn, Lansing legislative consultant, stressed the importance of medical families' involvement in politics.

Linda Kelly, MSMS/A legislative co-chairperson, chats with Thomas E. Stone, MD, chairman, MDPAC. Lois Duhamel, also MSMS/A legislative co-chairperson, is not pictured.

Representative Shirley Johnson (R-Royal Oak) addressed the problem of high infant mortality, and shared with the mostly-female audience her experience as a woman in the legislature.
Photos by Dick Wesley.

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USING A PATIENT SURVEY?

Have you developed or found a form for obtaining feedback from your patients? If you have, please share it with MSMS. The Public Relations Subcommittee of the Advisory Committee on Communications and Professional Relations wishes to review the forms that are in use, then develop a new one containing the *best* features from *your* samples.

Your comments about your patient survey form are welcome, too. Tell us what you like best, or least, about your version, and what you would do differently. Explain how you distribute forms, and how you evaluate the results.

Please send your sample forms and comments, anonymously if you wish, to Sheri Greenhoe, MSMS, 120 W. Saginaw, East Lansing 48823.

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Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of Dyrenium (triamterene, SK&F CO.) and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.
BRS-DZ:L39

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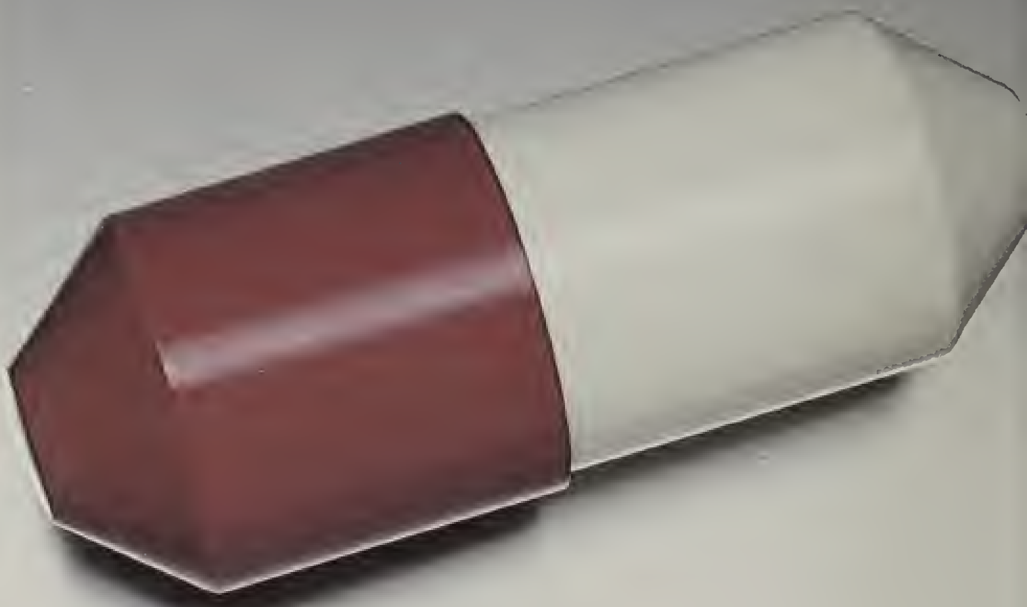

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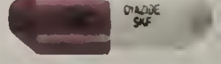

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DEATHS

James B. Blodgett, MD
Bloomfield Hills
Doctor Blodgett died January 23 at the age of 74. He graduated from Harvard University Medical School in 1936. Doctor Blodgett was known as one of Detroit's top heart surgeons and was former speaker of the MSMS House of Delegates.

Aaron L. Chapman, MD
Port Huron
Doctor Chapman died January 20 at the age of 98. He graduated from the University of Michigan Medical School and practiced medicine in Detroit for more than 50 years.

James W. Ferris, MD
Sarasota, FL
Doctor Ferris, formerly of Davison, died January 6 at the age of 73. Doctor Ferris was a general practitioner in Davison for 40 years and at Buick Motor Company for ten years before his retirement.

F. Sinclair Finch, MD
Grosse Pointe Woods
Doctor Finch died December 21 at the age of 71. Doctor Sinclair graduated from Wayne State Medical School in 1941. He served as a major in the US Army Medical Corps during World War II and was former chief of staff at Saratoga Hospital.

Nicholas Hnatchuk, MD
Lambertville
Doctor Hnatchuk died December 28 at the age of 83. He graduated from Gratz Austria Medical School in 1952. Doctor Hnatchuk was a practicing physician for more than 50 years.

Shmarya Kleinman, MD
Southfield
Doctor Kleinman died January 26 at the age of 94. He graduated from Donskey University Medical School, USSR, in 1920. Doctor Kleinman practiced internal medicine at Hutzel Hospital, Sinai Hospital, Metropolitan Hospital, and Crittendon Hospital and retired in 1981.

Christian F. Matthews, Jr., MD
Mt. Clemens
Doctor Matthews died January 19 at the age of 71. He graduated from Wayne State University School of Medicine in 1952. Doctor Matthews was past president of the Macomb County Medical Society and former chief of staff and surgery at St. Joseph Hospital.

Robert D. McKnight, MD
Harbor Springs
Doctor McKnight died October 8 at the age of 63. He graduated from Harvard School of Medicine in 1947. Doctor McKnight was affiliated with Burns Clinic in the department of internal medicine until his retirement in May, 1985.

William H. Meade, MD
East Lansing
Doctor Meade died January 19 at the age of 80. Doctor Meade graduated from the University of Michigan Medical School in 1930. He was former chief of surgery at St. Lawrence Hospital and assistnt clinical professor at the MSU School of Human Medicine.

Hyman L. Perlis, MD
Long Beach, CA
Doctor Perlis, formerly of Detroit, died November 10 at the age of 92. Doctor Perlis graduated from Wayne State University School of Medicine in 1919. He was a member of the Wayne County Medical Society and was honored for 50 years of service by MSMS in 1969.

Lorne D. Proctor, MD
Windsor, Ontario, Canada
Doctor Proctor, formerly of Wayne County, died January 4 at the age of 77. He graduated from the University of Toronto Medical School in 1938. Doctor Proctor was chairman of the department of neurology and psychiatry at Henry Ford Hospital and was on staff at St. Johns Hospital.

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Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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Michael Banka, MD—FP
1223 Mercy Drive
Muskegon 49444

Francis A. Bartek, MD—OBG
B-316 Clinical Center—MSU
East Lansing 48824

Howard J. Beck, MD—OTO
560 W. Mitchell
Petoskey 49770

Mark S. Blumenkranz, MD—OPH
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Royal Oak 48072

David G. Booth, MD—FP
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Temperance 48182

John H. Burrows, MD—IM/ON
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St. Clair Shores 48080

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21 Michigan St., NE #550
Grand Rapids 49503

Joseph R. Cline, MD—EM/IM
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Marquette 49855

Robert G. Cline, MD—AN
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Continued on page 208

Mutual Memo

1

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MSMS, MSMS/A, AMA & MEDICAL ASSISTANTS

April 23 — MSMS Practice Management Seminar: Medical Practice Collection, Marriott Inn, Grand Rapids, contact: Donna Farougi, MSMS headquarters (517)337-1351.

April 30 — MSMS Practice Management Seminar: Advanced Marketing, Marriott Inn, Grand Rapids, contact: Donna Farougi, MSMS headquarters (517)337-1351.

May 1-4 — Michigan Medical Assistants State Convention, Kalamazoo Center/Hilton Inn, contact: Phyllis Marquardt, RN, 1216 Forest Drive, Kalamazoo 49002 (616)327-9473.

May 2-3 — MSMS House of Delegates, Hyatt Regency Dearborn, contact: William Madigan (517)337-1351.

May 12-14 — MSMS/Auxiliary Annual Session, Grand Traverse Resort, Traverse City, contact: Viola M. Heins, MSMS headquarters (517)337-1351.

May 15 — MSMS Sports Medicine Conference, Clarion Convention Center, Lansing, contact: Sherry Fent, MSMS headquarters (517)337-1351.

May 21-14 — 9th Annual National Conference on Rural Health, co-sponsored by the AMA, Sheraton Harbor Island East Hotel, San Diego, contact: Donna M. Williams (816)421-3075.

May 28 — MSMS Hospital Medical Staff Section Leadership Conference, Novi Hilton, contact: Thomas White, MSMS headquarters (517)337-1351.

June 15-18 — AMA Auxiliary Annual Session, Drake Hotel, Chicago, contact: Viola M. Heins, MSMS headquarters (517)337-1351.

June 27 — MSMS Practice Management Seminar: Computers in the Medical Practice, Hilton Shanty Creek, Bellaire, contact: Donna Farougi, MSMS headquarters (517) 337-1351.

July 17-20 — MSMS Midsummer Board meeting, St. Clair Inn, St. Clair, contact: William Madigan (517)337-1351.

August 22 — Practice Management Seminar: Computers in the Medical Practice, Boyne Mountain, Boyne Falls, contact: Donna Farougi, MSMS headquarters (517)337-1351.

OTHER MEETINGS

May 1 — Michigan Chapter, American College of Surgeons, Coller Day Competition, Omni International Hotel, Detroit, contact: Viola M. Heins, MSMS headquarters (517)337-1351.

May 9 — Michigan Associate Scientific Meeting of the American College of Physicians, Hyatt Regency Flint, contact: Arnold R. Axelrod, MD, Chairman, Department of Medicine, Sinai Hospital, 6767 W. Outer Drive, Detroit 48235 (313) 493-5030.

May 12 — Annual Wayne County Medical Society Beaumont Lecture, St. John Hospital, contact: Roger Mecum, Executive Director, Wayne County Medical Society (313)567-1640.

May 17-18 — Michigan Society of Pathologists Immunopathy and Fine Needle Aspiration Lesions, St. Clair Inn, contact: Viola M. Heins, MSMS headquarters (517) 337-1351.

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SATURDAY, MAY 17

Government in Medicine 8:30 - 12:00
HEALTH CARE IN THE 1990'S
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HOSPITAL AND PHYSICIAN DRG'S
GRAMM-RUDMANN EFFECTS

Business in Medicine 1:00 - 4:30
UNDERSTANDING THE BLUES
IPA's, PPO's and HMO's
HOSPITAL-MEDICINE INC.'s
JOINT VENTURES

Concurrent Workshops 4:45 - 6:00
LEGISLATIVE UPDATE
REGULATORY UPDATE
EVOLVING PRACTICE PATTERNS

Negotiating Technique 7:30 - 9:00

SUNDAY, MAY 18

Medical-Legal Issues 8:30 - 12:00
MALPRACTICE
STAFF ORGANIZATION
SOCIETIES AND UNIONS
TRUSTS AND ANTITRUST

Afternoon Workshops 1:00 - 5:00
COST-EFFECTIVE PREVENTION
PHYSICIAN CONTRACTS
TORT REFORM
PEER REVIEW FUTURE

Negotiating Critique 7:30 - 9:00

MONDAY, MAY 19

Concurrent Workshops 8:30 - 12:00
PROFESSIONAL LIABILITY
NEGOTIATING PARTICIPATION

Concurrent Workshops 1:00 - 4:30
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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

Date: April 22, 11th Annual Infectious Diseases Symposium. Location: Amway Grand Plaza Hotel, Grand Rapids (1st session); East Auditorium, Butterworth Hospital (2nd session). **Sponsor:** Butterworth Hospital. **Contact:** Celia M. Steel, Continuing Medical Education, Butterworth Hospital, Grand Rapids (616)774-1835. **Approved for:** 6 hours Category I Credit (1st session) 1 hour Category I Credit (2nd session).

Date: April 23, Cancer Prevention and Early Detection. Location: Genevieve U. & Donald S. Gilmore Center for Health Education, Healthcare Plaza, Kalamazoo. **Contact:** Charles L. Zeller, Jr., MD, SMAHEC, Stryker Center, 4th Floor, 1521 Gull Road, Kalamazoo 49001. **Approved for 6 hours of Category I Credit.**

Date: April 26-30, Tutorial on Level II Manual Medicine Techniques (Below Diaphragm). Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: April 28, Annual Orthopaedic Clinic Day. Location: Children's Hospital Auditorium, Detroit. **Sponsor:** Children's Hospital of Michigan. **Contact:** Sheryl Boyd, Program Planner, Children's Hospital of Michigan, 3901 Beaubien Boulevard, Detroit 48201 (313)494-5456. **Approved for:** 6 hours of Category I Credit.

Date: May 1-3, Neonatal/Infant/Child Life Support. Location: Gilmore Health Education Center, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association and Southwestern Michigan Area Health Education Center. **Contact:** William H. Scott, MD, Southwestern Michigan Perinatal Association, 252 E. Lovell Street, Kalamazoo 49007 (313)383-6469. **Approved for:** 19 hours of Category I Credit.

Date: May 1-3, June 12-14, September 25-27, November 13-15, Neonatal/Infant/Child Life Support. Location: Gilmore Health Education Center, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association and Southwestern Michigan Area Health Education Center. **Contact:** William H. Scott, MD, Southwestern Michigan Perinatal Association, 252 E. Lovell Street, Kalamazoo 49007 (313)383-6469. **Approved for:** 19 hours of Category I Credit.

Date: May 1-3, Computed Tomography and Magnetic Resonance Imaging. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Betty Phillips, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor, MI 48109-0010 (313) 763-1400.

Date: May 2, Tenth Annual Preventive Cardiovascular Medicine & Rehabilitation Symposium. Location: Martin Verzi Auditorium at Borgess Medical Center, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center, Institute for Cardiovascular Health-Borgess Medical Center, American College of Sports Medicine, Michigan Heart Association, American Academy of Family Physicians. **Contact:** Jeffery P. Morgan, MA, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001.

Date: May 8-9, 1986 Cardiovascular Symposium and Workshop. Location: Martin Verzi Auditorium, Borgess Medical Center, Kalamazoo. **Sponsor:** Nuclear Cardiology, Borgess Medical Center and Southwestern Michigan Area Health Education Center. **Contact:** Philip B. Noack, Nuclear Cardiology, 1521 Gull Road, Kalamazoo 49001. **Approved for:** 11 hours of Category I Credit.

Date:May 8-9, The Phlebotomy Team: Technical and Management Perspectives. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Medical School. **Contact:** Jolene Glaspie, Towsley Center (313)763-1400. **Approved for:** 10.75 hours of Category I Credit.

Date: May 9-10, Inpatient Psychiatry-Integrating Multiple Interventions. Location: Weber's Inn, Ann Arbor. **Sponsor:** Chelsea Community Hospital Psychiatry Service. **Contact:** Frank Colligan, MD, Chelsea Community Hospital, 775 S. Main Street, Chelsea 48118. **Approved for:** 12 hours of Category I Credit.

Date: May 12-14, Real-Time Ultra-sound in Obstetrics and Gynecology. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School (313) 763-1400. **Approved for:** 21 hours of Category I Credit.

Date: May 12-16, Advances in Internal Medicine. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School (313)763-1400. **Approved for:** 35 hours of Category I Credit.

Date: May 15, Perinatal Passages. Location: Western Michigan University Student Center, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Assocation, Southwestern Michigan Area Health Education Center and American Academy of Family Physicians. **Contact:** Wendy Finsterwald, Southwestern Michigan Perinatal Associaton, 252 E. Lovell Street, Kalamazoo (616)383-6469. **Approved for:** 5.5 hours of Category I Credit.

Date: May 15, MSMS Sports Medicine Conference. Location: Clarion Convention Center. **Sponsor:** MSMS. **Contact:** Sherry Fent, MSMS headquarters (517)337-1351. **Approved for:** 5 hours of Category I Credit.

Date: May 15-17, Neuro-Ophthalmology and Visual Fields. Location: W.K. Kellogg Eye Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: May 16, Basic Cardiac Life Support Course for Physicians. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical Shool. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School 48109-0010 (313)763-1400. **Approved for:** 6 hours of Category I Credit.

Date: May 16, Physiological Monitoring. Location: Gilmore Health Education Center, Kalamazoo. **Sponsor:** Bronson Respiratory Care Department, Southwestern Michigan Area Health Education Center. **Contact:** Phyllis J. Wilson, Respiratory Care Department, 252 E. Lovell, Kalamazoo 49007. **Approved for:** 6 hours of Category I Credit.

Date: May 16-17, Advances in Pediatrics. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 9.5 hours of Category I Credit.

Date: May 17-18, Advanced Cardiac Life Support Provider Course. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 16 hours of Category I Credit.

Date: May 18-20, Neonatal Extracorporeal Membrane Oxygenation. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 13.75 hours of Category I Credit.

Date: May 21-23, 28th Annual Clinic Days: A Centennial Celebration. Location: Children's Hospital, Detroit. **Sponsor:** Wayne State University School of Medicine. **Contact:** Sheryl Boyd, Children's Hospital, 3901 Beaubien Blvd., Detroit 48201 (313)494-5456. **Approved for:** 12.5 hours of Category I Credit.

Continued on page 214

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Date: **May 21, The Brain and the Heart—A Current Look. Location:** Gilmore Health Education Center, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Chris Pearson, SMAHEC, 4th Floor, Stryker Center, 1521 Gull Road, Kalamazoo (616)383-6360. **Approved for:** 6 hours of Category I Credit.

Date: May 28-30, Current Topics in Blood Banking, 13th Annual Symposium. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Betty Philips, Towsley Center (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: May 28-June 1, Tutorial on Direct Action Thrust Manipulative Technique. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: June 5-6, 12th Annual Kalamazoo Symposium for Michigan Neonatologists and Neonatal Fellows. Location: Gilmore Health Education Center, Kalamazoo. **Sponsor:** Neonatology Service, Bronson Methodist Hospital and Southwestern Michigan Area Health Education Center. **Contact:** John V. Hartline, MD, Bronson Methodist Hospital, 252 E. Lovell Street, Kalamazoo 49007 (313)383-6469. **Approved for:** 6 hours of Category I Credit.

Date: June 5-6, Surgery Education. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: June 9-13, Principles of Manual Medicine. Location: Kellogg Center, MSU. **Sponsor:** MSU Colege of Osteopathic Medicine, College of Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: June 11-13, Clinical Laboratory Computers. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School 48109-0010 (313)763-1400. **Approved for:** 11.5 hours of Category I Credit.

Date: June 12-14, 37th Annual Keyport-Gaylord Trauma Symposium. Location: Hidden Valley Club, Gaylord. **Sponsor:** Wayne State University School of Medicine. **Contact:** Robert F. Wilson, MD, Wayne State University Department of Surgery, 6-C UHC, 4201 St. Antoine, Detroit (313)577-5009. **Approved for:** 15 hours of Category I Credit.

Date: June 12-14, Neonatal/Infant/Child Life Support. Location: Gilmore Health Education Center, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association and Southwestern Michigan Area Health Education Center. **Contact:** William H. Scott, MD, Southwestern Michigan Perinatal Association, 252 E. Lovell Street, Kalamazoo 49007 (313) 383-6469. **Approved for:** 19 hours of Category I Credit.

Date: June 22-27, 22nd Annual Northern Michigan Summer Conference: An Update on Common Clinical Concerns. Location: Hilton Shanty Creek, Bellaire. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 19 hours of Category I Credit.

Date: July 24-26, Clinical Nutrition Update. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 15 hours of Category I Credit.

Date: July 24-25, Coller Penberthy Thirlby Medical Conference. Location: Grand Traverse Resort, Grand Traverse Village. **Sponsor:** Munson Medical Center. **Contact:** Norma Powers, Coordinator of Medical Education, Munson Medical Center, 6th and Madison, Traverse City 49684 (616)922-9544. **Approved for:** 9 hours Category I Credit.

Date: July 25-28, Advances in the Management of Infectious Diseases. Location: Grand Hotel, Mackinac Island. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)7631400. **Approved for:** 12 hours of Category I Credit.

Date: August 1-3, Tutorial on Level II Myofascial Release Technique. Location: Homestead Resort, Glen Arbor. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing (517)353-9714. **Approved for:** 24 Hours of Category I Credit.

Date: August 17-20, Internal Medicine Update. Location: Grand Hotel, Mackinac Island. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michgian Medical School 48109-0010 (313)763-1400. **Approved for:** 33.75 hours of Category I Credit.

Date: September 3, Update '86—Rehabilitation of Traumatic Brain Injury. Location: Kalamazoo, Michigan. **Sponsor:** West Michigan Physiatry, PC and Southwestern Michigan Area Health Education

Contunued on next page

CLIFF JOHNSON

"You'll have to cut down on your eating habits, Mr. Baxter. A snack before breakfast *really* isn't necessary!"

Center: **Cost:** $50. **Contact:** Doctor Bryan Visser, West Michigan Physiatry, PC, 252 E. Lovell Street, Suite 363E, Kalamazoo 49007. **Approved for:** 5.75 hours of Category I Credit.

Date: September 6, Basic Cardiac Life Support Course for Physicians. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Date: September 6-7, Chief Surgical Residents. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: September 7-8, Advanced Cardiac Life Support Provider Course. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School (313)763-1400. **Approved for:** 16 hours of Category I Credit.

Date: September 12-13, Parinatal and Enteral Nutrition 1986: Clinical Update. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: September 12-13, Hypertension 1946-1986: The First Ann Arbor International Reunion. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313) 763-1400. **Approved for:** 12 hours of Category i Credit.

Date: September 13-17, Tutorial on Level I Muscle Energy Technique. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: September 25-27, Neonatal/Infant/Child Life Support. Location: Gilmore Health Education Center, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association and Southwestern Michigan Area Health Education Center. **Contact:** William H. Scott, MD, Southwestern Michigan Perinatal Association, 252 E. Lovell Street, Kalamazoo 49007 (313) 383-6469. **Approved for:** 19 hours of Category I Credit.

Date: September 25-27, Diagnostic Ultrasound. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 15 hours of Category I Credit.

Date: September 26-28, Tutorial on Level I Myofascial Release Technique. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 24 hours of Category I Credit.

Date: September 29-October 1, Hemodynamic Monitoring and Management Seminar. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 14 hours of Category I Credit.

Date: October 1-3, Mechanical Ventilatory Support and Management. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical

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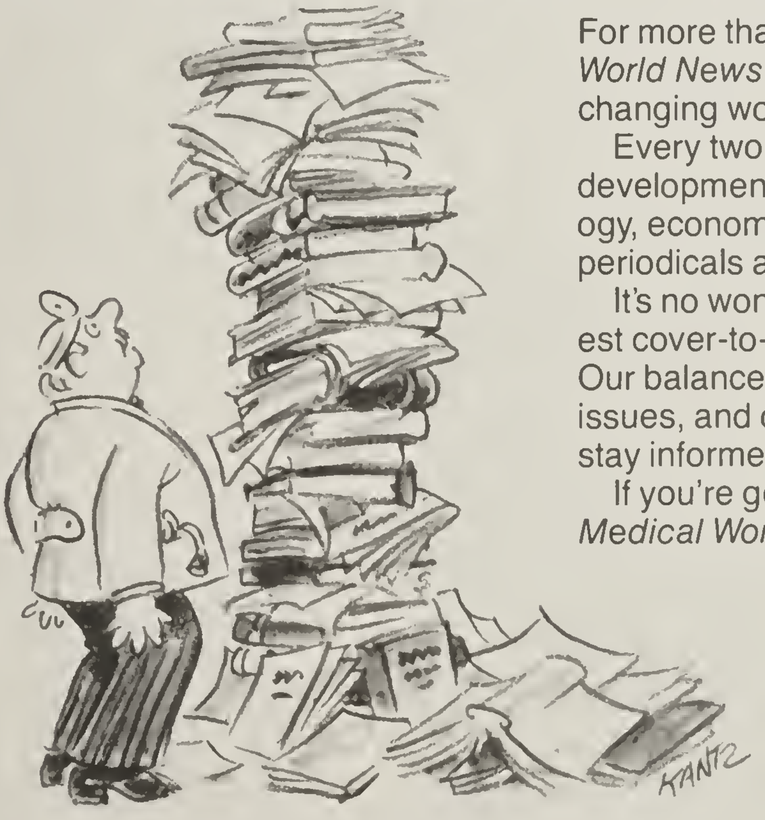

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School, Ann Arbor 48109-0010 (313) 763-1400. **Approved for:** 15 hours of Category I Credit.

Date: October 2-3, Diabetes Care. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical Shool. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 16 hours of Category I Credit.

Date: October 4-5, National Conference for Chief Medical Residents. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313) 763-1400. **Approved for:** 10 hours of Category I Credit.

Date: October 9-10, Ear, Nose and Throat Practicum. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 16.5 hours of Category I Credit.

Date: October 9-10, Ins and Outs of Critical Care: Fluids, Nutrition and Renal Management. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010, (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: October 11-15, Tutorial on Level II Manual Medicine Techniques (Above Diaphragm). Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: October 16-17, Perinatology and Neonatology. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: October 16-18, Common Surgical Problems in Childhood. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 18 hours of Category I Credit.

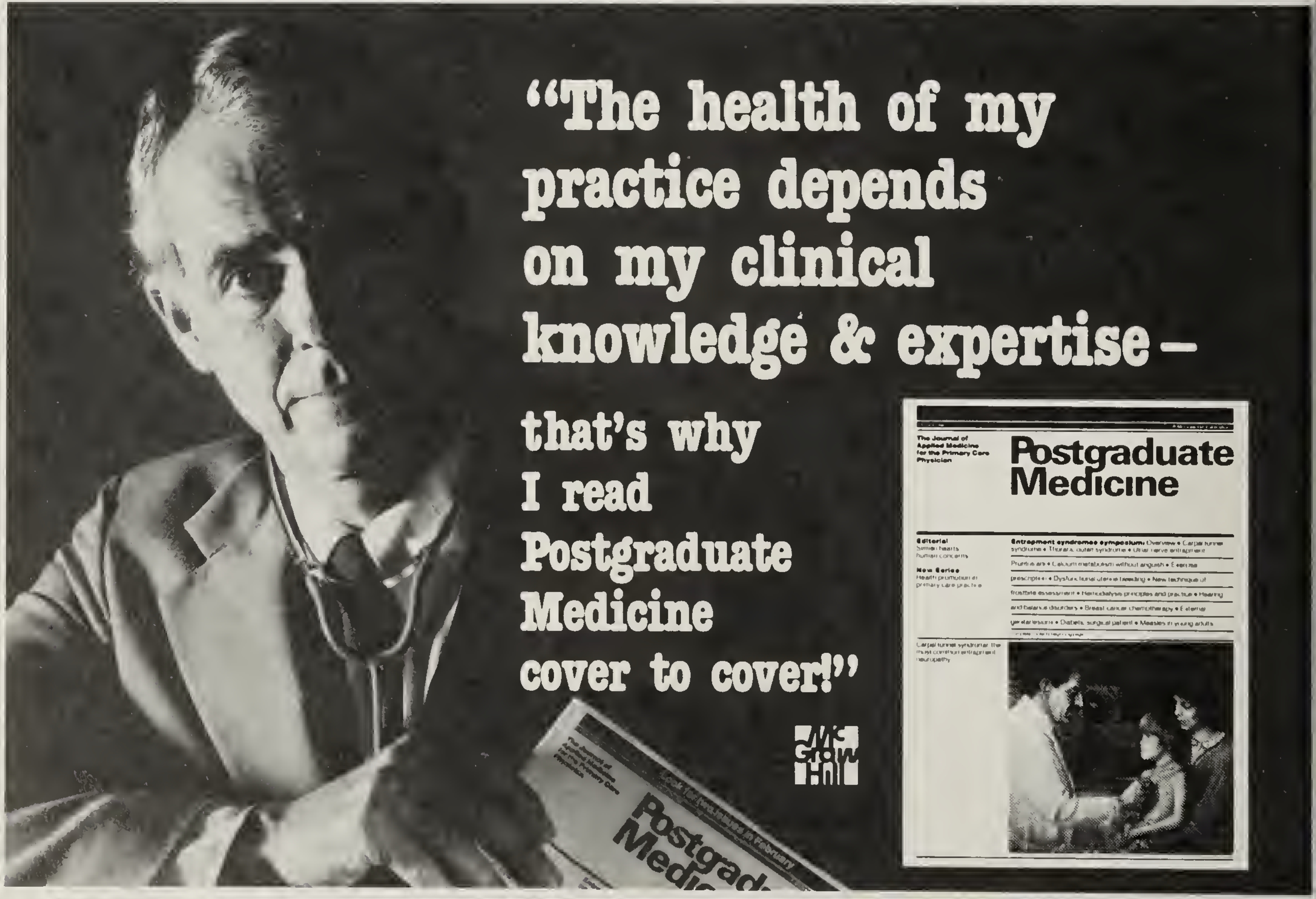
Date: October 19-23, Tutorial on Level II Craniosacral Techniques. Location: Kellogg Center, MSU. **Sponsors:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: October 20-21, Care of the Elderly. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-0010. **Approved for:** 12 hours of Category I Credit.

Date: October 24-25, Advances in Multidisciplinary Approaches in the Treatment of Cancer of the Breast, Head and Neck, and Ovaries. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 10.5 hours of Category I Credit.

Date: October 24, Basic Cardiac Life Support Course for Physicians. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 6 hours of Category I Credit.

Date: October 25, Advanced Cardiac Life Support Course Recertification. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 8 hours of Category I Credit.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Date: October 27-29, Impairment Evaluation and Disability Considerations: Medical and Legal Perspectives. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 17 hours of Category I Credit.

Date: October 30-November 2, Chest Radiology: Pioneers and New Frontiers. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 14 hours of Category I Credit.

Date: November 7, Basic Cardiac Life Support Course for Physicians. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 6 hours of Category I Credit.

Date: November 7-9, Tutorial on Manual Medicine Techniques Applied to the Extremities. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 24 hours of Category I Credit.

Date: November 8-9, Advanced Cardiac Life Support Provider Course. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 16 hours of Category I Credit.

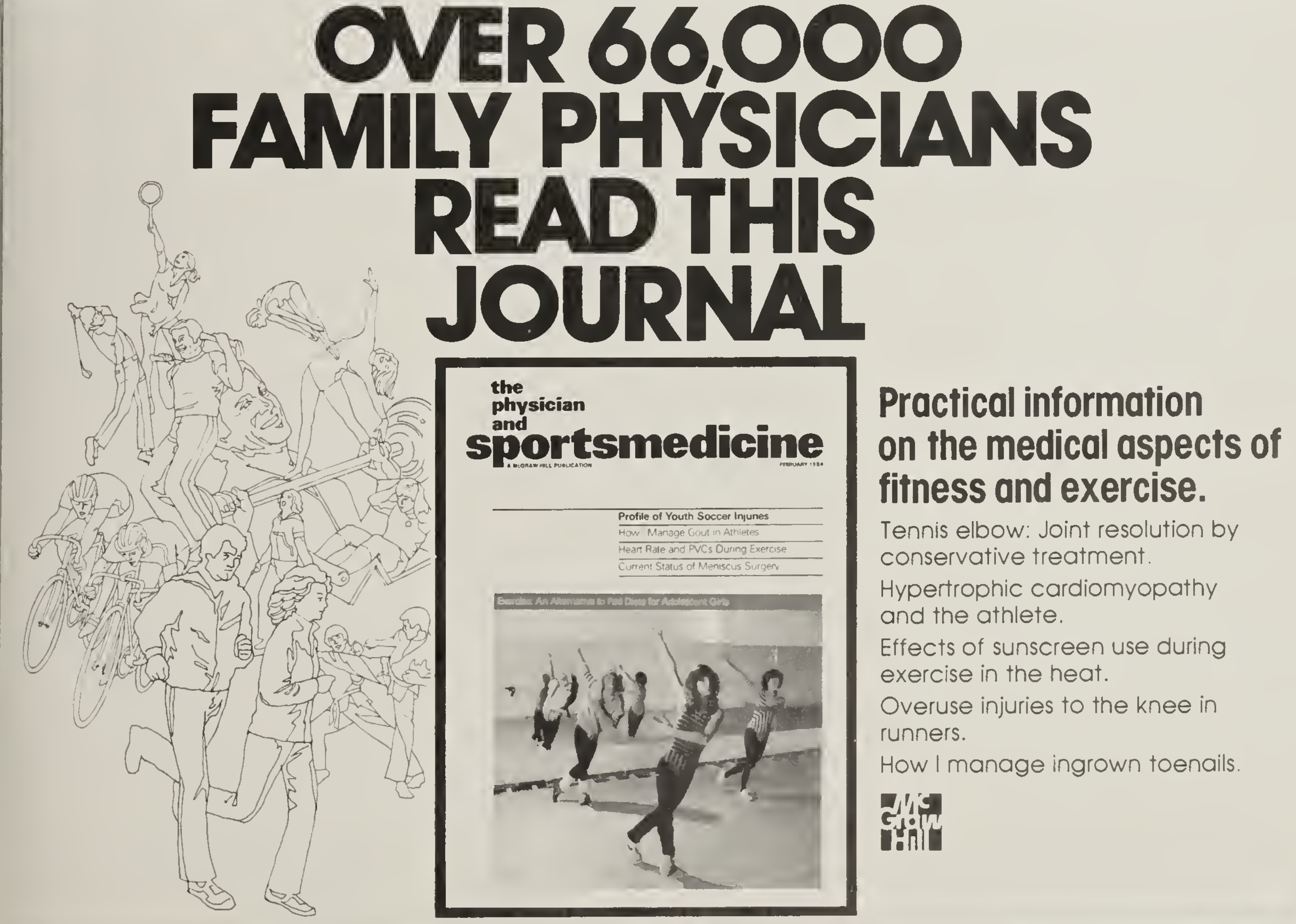
Date: November 12-14, Real-Time Ultrasound in Obstetrics and Gynecology. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 21 hours of Category I Credit.

Date: November 13-15, Neonatal/Infant/Child Life Support. Location: Gilmore Health Education Center, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association and Southwestern Michigan Area Health Education Center. **Contact:** William H. Scott, MD, Southwestern Michigan Perinatal Association, 252 E. Lovell Street, Kalamazoo 49007 (313)383-6469. **Approved for:** 19 hours of Category I Credit.

Date: November 17-18, Laser Medicine and Surgery: The Aerodigestive Tract. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 17 hours of Category I Credit.

Date: November 19-21, Laser Medicine and Surgery: Specialty Applications. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 22.5 hours of Category I Credit.

Date: December 15-19, Principles of Manual Medicine. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine, College of Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.



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By Richard J. McMurray, MD

The coincidental poor result

With this column Doctor McMurray concludes one year of correspondence through *Michigan Medicine*, and looks forward to his new leadership role as Immediate Past President, which he will assume in May.

Has its time come? There has always existed in the practice of medicine the poor result where a disease, once present, defies all medical treatment and progresses with varying speed toward permanent disability or death. All of us as physicians are very familiar with what could be classified as the "general poor result." This generally is not the focus of a medical liability claim unless an instance of "failure to diagnose" is alleged.

As opposed to the general poor result (GPR) the coincidental poor result (CPR) merits special consideration, not only by physicians who are blamed for it under the false term "malpractice," but by society which to date has ignored altogether that which is clearly its responsibility. Coincidental poor results are defined as those unpredictable misfortunes that occur in the practice of medicine during or subsequent to any test or treatment performed correctly with all reasonable precautions and with solid valid indications. The victim of this fate, if he survives, often is left with a devastating disability, and, mindful of a bleak and dependent future, he or his family, being doomed to welfare roles, adopt the only course open to them.

The sequence of lawyers and courtrooms now awaits the anguished and completely innocent physician whose only fault was that, in all good faith, he attempted to help another human being.

Who pays?

This travesty of justice is many-layered. The desperate claimant has an undeniable need. While he or his lawyer may be perfectly aware of the physician's innocence, it must be against the physician that the claim of "malpractice" is charged as the claimant has no other place to turn. It is rationalized that it is the insurance company and not the doctor that pays, therefore the doctor will not be hurt. The lawyer clears the way for the poor man to have his day in court where, justice being done, he satisfies his thirst by swallowing up to half the settlement. The insurance company now recovers by increasing the physician's premium. The physician, convicted yet innocent, his very life work threatened and abused now limits his practice, moves away, or retires not happily, but disillusioned and in disgust.

There is no mechanism in society today to support the victim of a coincidental poor result. It seems that even in the free enterprise system certain socialistic measures cannot be avoided, thus CPR for strong moral reasons must be afforded relief. Sympathy cannot be eaten. People ultimately are the responsibility of people.

A compensation fund

Doctors of medicine, although they currently are being blamed and punished for the coincidental poor result, are not without fault for ignoring their medical-political duties by not establishing care funding for these victims through the legislature. Because we have no other recourse, we must accept the possibility of a bureaucratic fiasco and establish a broad financiallly-based compensation fund. The profession must define the CPR as a precursor to providing aid. This can only be done by doctors of all categories of medicine relying on their cumulative experience.

If a CPR board were to exist, only rigidly defined situations would be admissable, judgments final, and without recourse to arbitration or courts of law. Paid by the general fund, such a board comprised of doctors and laymen would be exempt from liability for any case in which they sit in judgment.

This effort should be embraced by medicine, not only as a duty to the public but as a significant attempt to separate maloccurrence from malpractice, to provide for the medical misfortune, and to improve the quality of medical life.☐

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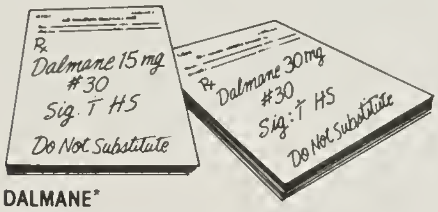

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MICHIGAN MEDICINE

May 1986 AWARD-WINNING JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 85, No. 5

Board of Medicine and physician competency

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May 1986, Vol. 85, No. 5

MICHIGAN MEDICINE

MICHIGAN MEDICINE

About the cover: The Michigan Board of Medicine is responsible for licensing, examination and regulation of Michigan doctors of medicine. The 14-member body is made up of physicians and laymen. The physician members are pictured on our cover. They are, (front row, left to right): Charles C. Vincent, MD, chairman; Larry J. Andreini, MD; Rachel B. Keith, MD; Emma J. Conklin, MD; (back row) Norman J. Bolton, MD; Philip M. Margolis, MD; Richard H. Wakulat, Jr , MD; John A. Ingold, MD; and George J. Tsiatalas, MD. Stella Evangelista, MD is not pictured. *Photo by Pattrick Yockey*

In next month's issue of *Michigan Medicine:* The organ transplant picture in Michigan.

Special Report

224 Physician competency is one of the most significant issues facing the medical community today. There exists a large national, state and local system working to protect the public by establishing and enforcing competency standards. This Special Report takes a close look at two slices of this system: The Michigan Board of Medicine and continuing medical education. There are interviews with the physicians who head up the Board of Medicine, and profiles of new Board members; a review of the Board's regulatory function; an overview of CME record-keeping and MSMS for-credit opportunities, and a list of organizations accredited to offer CME programs. Sheri W. Greenhoe; Raymond W. Hood, Jr.; Judy Marr.

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By Harvey M. Andre, MD

The changing times

Andre

Almost three decades ago I first served as an alternate delegate from my county to the MSMS House of Delegates. We all know there have been radical changes in the delivery of health care since then, and that we are now faced with a ''malpractice crisis.'' I have been trying to recall what were the ''hot'' issues of 30 years ago. Frankly there was no issue anywhere near as important as our present crisis.

Every year in those days there were resolutions submitted concerning our problems with Blue Cross Blue Shield. For the information of some of our younger members, it should be stated that Blue Shield was originally started by MSMS to establish an insurance program to cover major medical expenses for the public. This was an outgrowth of the Great Depression, when many people simply had no money to pay doctors' fees, even though a house call in those days was only three dollars!

Our baby

Yes, we started Blue Shield to help our patients. However, by legislative and bureaucratic changes, our baby became an overgrown monster. I well remember when the annual meeting of the BCBS corporate body was a special meeting of the delegates, sandwiched in between the session of the House of Delegates. However, we gradually had less and less to say, and the ''consumer'' members increased in numbers. When things occurred that the subscribers did not like, the suggestion was ''Tell your doctors — it is their organization!''

In those days we had ongoing battles with BCBS, just as we do today, regarding fees, screens and regionalization of fee schedules. However, we found ourselves without any clout with the organization we originally sponsored. This situation brought about many

Continued on next page

Doctor Andre, chairman, MSMS Committee on Publications and member, MSMS Board of Directors, retires with this column after having served MSMS well for three three-year terms.

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CHANGES/Continued

more resolutions in the House.

Another concern, closely connected to the above, was the Relative Value Scale. This too had inequities in it.

The relationship between the hospital administrative board and the medical staffs was another problem. This grew to very serious confrontations in some instances. As a result of many resolutions, it became MSMS policy that we advocate physician membership on hospital administrative boards. Many hospitals now have such an arrangement. With rigid governmental regulations, such as DRGs, the hospitals find they too must battle the government, just as the doctors have been doing for years.

Today's concern

These were some of the major problems we faced over the years, but as serious as they were, they did not begin to compare with our present problem with malpractice insurance.

Only when the general public realizes that medical services may not be available and citizens put enough pressure on the legislators to override the legal and union lobbyists, will we have proper legislative relief.

Yes, times have changed. How minor some of the issues of two or three decades ago appear in comparison to today's big issues — the liability crisis and the very survival of our profession. ☐

More on Doctor Van Hoosen

May I take this opportunity to commend Mr. Herbert A. Auer for presenting us the documentary about Bertha Van Hoosen in *Michigan Medicine*, March, 1986. It is not only a credit to Michigan, her home state, but Avon Township and Rochester, as well as Chicago and, of course, women physicians nationally and internationally.

Even though my career was one in research and pathology, I always have been deeply appreciative that Doctor Van Hoosen was my mentor and friend throughout my career, and chose me along with several others to be her *surgical daughters*.

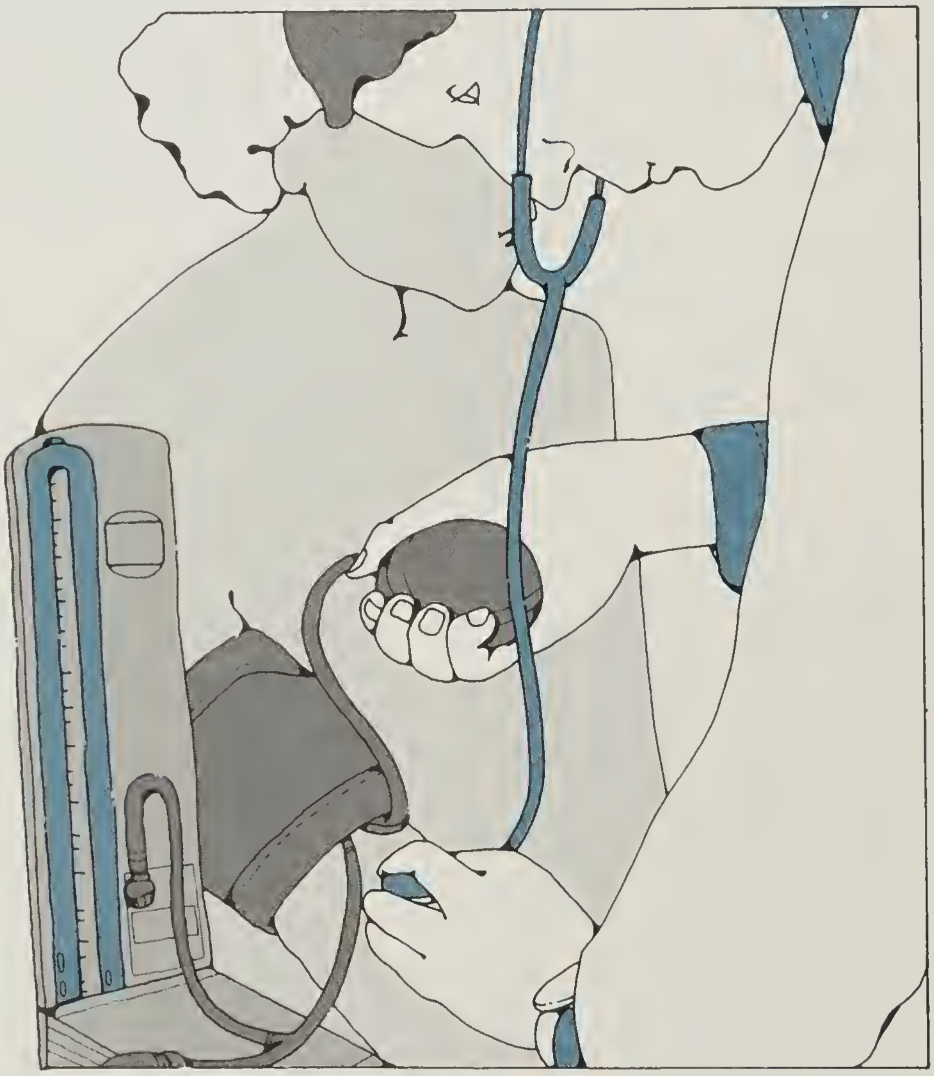
I felt deeply honored when I was chosen to receive the plaque awarded to Bertha Van Hoosen by the Michigan Women's Hall of Fame which I in turn presented to the Van Hoosen Museum to be placed next to her portrait. During the years I have collected many momentos, and with the help of several colleagues, prepared an exhibit entitled "Petticoat Surgeon, Bertha Van Hoosen, 1863-1952." It has been shown at a number of meetings of the American Medical Women's Association in the US, and most recently at an international conference in Vancouver.

The old historic Van Hoosen homestead now is a museum and historic marker which has seen the ravages of time. $100,000 has been allocated for repairs. When the repairs are completed my exhibit will find there a resting place.

Clara Raven, MD
Detroit

By Raymond W. Hood, Sr.

Assuring physician competency in Michigan



The question of physician competency is one of the most significant issues facing the medical community today. There are as many approaches to the problem of competency assurance as there are components of it. Who is responsible for assuring competency? How is it measured? When and how often should it be evaluated? One piece of common ground, however, is the recognition that competency of physicians does have a direct bearing on the quality of the health care delivery system in Michigan.

The Bureau of Health Services, in the Department of Licensing and Regulation, houses the thirteen licensing boards which are responsible for the original licensure of health practitioners (including physicians) as well as monitoring their activities for compliance with the Michigan Public Health Code and Administrative Rules.

Although the Bureau of Health Services has routine interaction with physicians throughout their professional careers regarding licensing, very few have direct contact with the allegation and investigation program. What follows is a brief desciption of the regulatory function which begins with processing allegations, conducting investigations and determining violations of the Public Health Code, and continues through the administrative hearing process culminating in board administered disciplinary action.

Public Health Code mandate

Section 16221 of the Public Health Code sets forth a variety of activities which may be investigated by the Department. These activities include incompetency, negligence, criminal convictions, substance abuse, prohibited business practices and fraud.

The Public Health Code and the Administrative Procedures Act provide the authorization and guidance for the Department and Board to carry out their mission: protecting the public health, safety and wel-

Mr. Hood is director, Michigan Department of Licensing and Regulation.

fare of the citizens of Michigan.

Allegation process

Patients and the families of patients most commonly file complaints. In come cases attorneys file allegations on behalf of patients or a peer may bring a situation to the Department's attention. Allegations also come from hospital disciplinary reporting and criminal conviction reporting from the Federal Court.

Allegations generally reflect the public's perception of a physician's conduct in terms of his professional competency. Many allegations result from a lack of communication between the patient and physician. These cases present a unique problem, in that although the health care consumer feels he has a legitimate complaint which warrants attention, an actual violation of the Public Health Code has not occurred. Time and resource limitations have prevented the Department from developing a system to more satisfactorily handle consumer problems of this type.

Allegations related to physicians are reviewed in committee by three appointed members of the Board of Medicine and a Department representa-

Continued on next page

The full Board of Medicine, including MDs and lay members, consists of (front row, left to right): Charles Vincent, MD, chairman; Philip Margolis, MD; Patricia Riggs; staff member Gen Dionese, who recently retired after 20 years of service to the Board; Karen Koch; Rachel Keith, MD; Emma Conklin, MD; (back row): Norman Bolton, MD, vice chairman; Larry Andreini, MD: Russ Boltz; George Tsiatalas, MD; Richard Wakulat, MD and John Ingold, MD. Thomas White is not pictured.

tive. The substance of the information is evaluated to determine if a violation of the Public Health Code may have occurred. Medical records are sometimes requested to assist in this determination. An allegation is either designated for investigaton or dismissed.

Investigation process

The investigation process follows a series of steps to gather facts, evidence and testimony. The complainant, other treating physicians and various other individuals are interviewed. Patient records and relevant documentation are obtained. In the course of the investigation, the subject physician is most always interviewed.

When the investigation is completed, reports are forwarded to the Health Professionals Division of the Department of Attorney General. The Assistant Attorneys General in this Division act as both legal counsel to the thirteen health boards and as legal counsel to the Department.

The investigation reports are reviewed by an Assistant Attorney General to determine if a violation has been established and if evidence exists to support the violation. At this point the investigation reports and medical records are typically reviewed by a physician, independently contracted by the Department as an expert. The purpose of this review is to determine if the prevailing standard of care has been met. If a violation of the Public Health Code can be supported, a formal complaint is drafted by the Assistant Attorney General. The complaint then proceeds through the administrative process.

Administrative process

Once a formal complaint is filed it is served upon the licensee who then has an opportunity to respond to the charges and request an informal conference. The informal conference allows an opportunity for the parties, the licensee and his/her attorney, and the Assistant Attorney General to discuss the facts in question. The informal conference can result in settlement; the physician may stipulate to the charges and to a disciplinary sanction. If disputes of fact and law exist after this informal conference the case enters the administrative hearing process. The administrative hearing is much like a trial. Evidence is presented and testimony is taken before an Administrative Law Judge. The Administrative Law Judge then issues Findings of Facts and Conclusions of Law which are transmitted along with other pertinent records to the Board of Medicine for final disposition.

Board of Medicine review

All formal complaints are ultimately presented to the Board of Medicine for final action.

The Board reviews all consent orders and stipulaton agreements where the physician has agreed to accept a disciplinary sanction. The Board may accept or reject this agreement.

The Board also reviews all matters that proceed through the administrative hearing process. After review of the hearing records, the Board may impose a disciplinary sanction as allowed under Section 16226 of the Public Health Code. The Board may also deliberate upon the matter and dismiss the charge if found unsubstantiated by the hearing record.

The process just described is one which has, for the most part, served the system well. The dynamics of society in general, and the medical profession in particular, however, demand that we, as the agency responsible for regulating the profession continually rethink our process. How can we be more responsive to consumers? How can we better serve our licensees? How can we maximize our limited resources?

Future directions

In mid 1985, the Board of Medicine and the Department of Licensing and Regulation undertook a pilot project to more carefully assess incoming allegations to ensure investigative pursuit of those with merit. Additional information is often gathered at this stage by an analyst in order to assist the allegation committee in their determination. Elimination of allegations without foundation has provided for a more timely investigation of meritorious ones.

The Department has also developed a program to identify and act upon all criminal convictions of licensees which take place in the Federal Eastern District Court. This process is handled by administrative staff and saves investigative time and resources. This program has been so successful that it will be expanded to other courts in the future.

Another area currently being reviewed by the Department is the general problem of chemical dependency among health professionals. The impaired professional requires a unique response not only in terms of the public's safety but also the well-being and productivity of the practitioner.

The Department of Licensing and Regulation in conjuncton with the Board of Medicine will continue its efforts to preserve and promote the quality and integrity of the health care delivery system in Michigan. It is a job we cannot do alone, however. Without the commitment and cooperation of the professional we cannot address today's problems or meet tomorrow's challenges. ☐

By Judy Marr, Editor

New Board of Medicine chairman discusses priorities

"If we get tort reform, everyone will expect a stronger Board. That means we will be writing more tickets."

The chief officer of the state's physician regulation arm, Charles C. Vincent, MD, Detroit, speaks firmly. He is new chairman of the Board of Medicine.

Doctor Vincent, associate dean for admissions at Wayne State University School of Medicine, has a message to pass along to his colleagues across the state:

"Pay attention to the Board of Medicine actions, and know the rules and regulations which apply to your practice."

"Being on the Board has been an eye-opener for me," he continues. "As a practitioner I was unaware of the amphetamine rules, or of the restrictions involved in writing a back-to-work note for a patient.

"There are many small things doctors do every day which may not be in compliance with state laws and codes. I practiced, as many doctors do, without reading that important information provided by MSMS and the Michigan Department of Licensing and Regulation."

Both Doctor Vincent and new Board Administrator Thomas J. DeKornfeld, MD, emphasize that it is the Board's job to protect the public, not to protect physicians.

"I often remind myself of the AMA Principles of Medical Ethics statement," says Doctor Vincent, "that a physician should 'expose without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession.' That's the responsibility one assumes with membership on the Board."

Doctor Vincent has been a member of the Board for three years. The governor reappointed him in 1986, but the Board in November, 1985, elected him to succeed James Fenton, MD, Bay City, as chairman.

Doctor Vincent says he finds the chairmanship a very interesting position, but not much different from Board membership. "All meetings are open to the public (which is rather unique to Michigan) and all members are fully aware of Board actions."

He is particularly concerned with the battle to win immunity for Board members. That provision is part of pending governmental liability reform legislation.

"We continue to be told we must take a more active role, yet as soon as we do, we are slapped with lawsuits," explains Doctor Vincent.

Since he has been on the Board, members have been sued four times. Three of the lawsuits are pending, while one was settled in the Board members' favor in February.

"I would expect the others that are pending to come our way, too," Doctor Vincent said. "But just the idea of a lawsuit hanging over our heads does affect our decision-making.

"When we discuss matters at Board meetings we must feel obligated to invoke penalties upon our colleagues even to the extent of suspending or revoking a license. But we know we're putting our personal assets on the line for the protection of the citizens we represent."

Eliminating backlog

Other major tasks ahead, he says, are eliminating the backlog of cases pending before the Board, and developing a closer working relationship with MSMS.

He recalls during his tenure when there was a large number of pending cases. "We are now down to 20 or so, many of which are referable to alleged malpractice suits. I hope with tort reform, there will be some lessening of the horrendous number of suits filed."

Continued on next page

VINCENT/Continued

The Department of Licensing and Regulation is computerizing the review process, which "at least makes it easier to review cases," he says.

He looks forward to using a brand-new program being developed by Board of Medicine Vice Chairman Norman F. Bolton, MD, Detroit, and Carl A. Gagliardi, MD, MSMS Board chairman, who also heads the MSMS Impaired Physician Program. Doctor Vincent says the new program can be in place before the end of the year.

The new program will work like this:

A hospital may report a disciplinary action, perhaps a suspension of a doctor's privileges for a year due to substance abuse problems. The Board will review the complaint, and after investigation, have the physician meet with the Board in a Compliance Conference.

If the Board finds the problem indeed is one of alcohol abuse, it might place strict limitations on the physician's license or suspend it.

"At the same time," says Doctor Vincent, "the Board could make the doctor's return to practice possible pending the MSMS Impaired Physician Committee's OK. Then the doctor would be encouraged to enter the program. When the program members felt the doctor was ready, he or she would come before the Board again and the Board's prior decision could be altered.

"The current system is not effective," continues Doctor Vincent. "What we're doing now is very piecemeal. While it is not our responsibility to assist physicians in this manner, it obviously allows us a method of helping impaired doctors re-enter practice, often in areas where their services are much needed."

And, there is the issue of inadequate funding of the Board. There currently are just eight state investigators for all 14 licensing boards. The same agents investigate beauticians, barbers, dentists, physicians, etc.

"This is totally inadequate," says Doctor Vincent. "We physicians pay large sums for our licenses, yet we barely get 50 cents back on the dollar for the Board of Medicine."

Doctor Vincent would prefer to see the Board have its own full-time attorney and six investigators "who would only work for us." Physicians' fees for licensure should go to the Board, he believes. (Pending legislation supported by MSMS would ensure this.)

Doctor Vincent would like to see more joint activities with MSMS, particularly in the legislative arena.

"Through MSMS's greater lobbying efforts, we will get more financial support and assistance," he says. But he's grateful for what's been done.

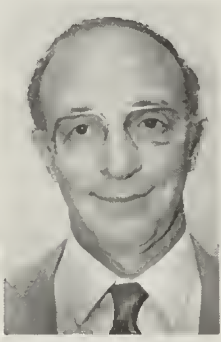
"MSMS has been there when we've needed it."☐

Meet new members of the Board of Medicine

Evangelista

Ingold

Keith



Margolis

Stella S. Evangelista, MD
Livonia

Graduated Benemeritus Doctor of Medicine, University of Santo Tomas, Manila, Philippines, 1968. Certified, American Board of Pediatrics, 1973. Chairperson, Department of Pediatrics, St. Mary's Hospital, Livonia, 1980-83; Chairperson, Scholarship Committee, Philippine Medical Association of Michigan, 1984-86; Secretary, University of Santo Tomas Medical Alumni Association of Midwest, 1986-87; Outstanding Filipino Woman of the Year in Community Participation, 1985.

Rachel B. Keith, MD
Detroit

Graduated Doctor of Medicine, Boston University School of Medicine, 1949. Senior Attending Physician, Internal Medicine at both Hutzel Hospital and Detroit Memorial Hospital. Associate Staff Physician at Sinai Hospital. Clinical Assistant Professor, Wayne State University School of Medicine. Served on Governor's Commission for the Future of Higher Education, 1983-85; Commissioner, Health Advisory Council, City of Detroit; Co-chairman, Main Task Force for Substance Abuse, City of Detroit, 1985-86.

John A. Ingold, MD
Birmingham

Graduated Doctor of Medicine, University of Michigan Medical School, 1956. Board certified, General Surgery, 1967; Board eligible, Radiation Oncology, 1964. Current Chief, Renal Transplant Team; Vice Chief, Department of Surgical Services, and Director of OR Services, William Beaumont Hospital, Royal Oak. Adjunct Assistant Professor of Surgery, Wayne State University School of Medicine.

Philip M. Margolis, MD
Ann Arbor

Graduated Medical Doctor, University of Minnesota, 1949. Diplomate, American Board of Psychiatry and Neurology, 1958; Examiner, 1959-66 and 1973-present. Associate Chief of Clinical Affairs, University of Michigan Hospitals; Team Leader, Outpatient Psychiatric Riverview Clinic Department of Psychiatry; Professor, Community Mental Health, School of Public Health, U-M; Professor, Department of Psychiatry, U-M Medical School. President-elect, Washtenaw County Medical Society.

By Judy Marr, Editor

Administrator appointed to add muscle to Board of Medicine

On a sunny spring afternoon, Thomas J. DeKornfeld, MD, is at work on the fourth floor of Lansing's North Ottawa Tower. That's one of the monolithic state office buildings north of the Capitol, and it's home to the Department of Licensing and Regulation.

It's warm in Doctor DeKornfeld's office, as his position entitles him to a view, and the sun is streaming in the windows.

This is one of the days each week that Doctor DeKornfeld spends in Lansing as he eases into his new job as Board of Medicine administrator. In July, Doctor DeKornfeld will hold the position full-time. He still spends the rest of the week in Ann Arbor, where he is professor and interim chairman of the Department of Anesthesia and professor of Postgraduate Medicine and Health.

The administrative post to which Doctor DeKornfeld was appointed in January was created to help strengthen the Board of Medicine. Pending legislation also seeks to increase the Board's funding and to provide immunity to Board members in their duties.

MSMS has been instrumental in lobbying for these needed changes.

"There's an absolute need for the Board, MSMS and the Department of Licensing and Regulation to work together," says Doctor DeKornfeld. "Nobody can do this job alone."

The job he refers to is the protection of the patient. "That's both our legislative mandate under the Public Health Code and our ethical mandate under the Oath of Hippocrates," he emphasizes.

Doctor DeKornfeld says he is "most anxious" to work closely with MSMS, county medical societies and hospitals, "to assist in any way I can."

Understanding the Board

Education of physicians and consumers about the role and purposes of the Board is of paramount importance to Doctor DeKornfeld. He plans extensive personal outreach to accomplish those goals.

"We're talking about a major and expensive job, but it needs to be done," says Doctor DeKornfeld. "This is a PR job in the very best sense of the word—not propaganda or a snow job.

"We have to get the consumer to accept and understand that the Board's sole purpose is to protect the people of Michigan. Physicians have to understand that without their cooperation and assistance it would be impossible for the Board to do."

Doctor DeKornfeld, a native of Hungary, has had a distinguished career in medicine, education and communications. He sees his new role as two-fold: to staff the Board, making it possible for the members to do their work more easily and consistently, and to serve as a liaison with the Board and governmental agencies, professional organizations, physicians and the public.

He lists the malpractice crisis and its implications, the question of continued education and competency assessment, foreign medical school approval and physician and public education as major issues before the Board.

He would like to see the legislature, through tort reform, streamline the procedures and processes dealing with negligence, "without in

Continued on next page

any way curtailing the consumer's right for redress if injured by negligence or incompetence."

"The thing that would help more in mitigating the malpractice crisis," he says, "is for physicians to come forward and report cases of obvious negligence or incompetence, of substance abuse, or senile or irrational behavior. This would allow the Department and Board to take the appropriate action.

"I appreciate very much how difficult it is to blow the whistle on a colleague and friend," he continues. "But I feel very strongly that we owe this to our patients. Many causes for incompetence are treatable and physicians must come forward and make it possible for their colleagues to receive the best possible care in rehabilitation and treatment."

There's a very serious question as to whether continued competency assessment is possible or economically feasible, says Doctor DeKornfeld.

"Which really leaves continuing education as the only method to respond to the public's demand for some assurance of physicians' continued ability."

Efficient CME

Doctor DeKornfeld revealed he is working to make continuing education more efficient and effective. His ideas include restructuring CME categories and tightening the course approval mechanism.

It is going to be increasingly more difficult for FMGs to get entry to and training in the US, says Doctor DeKornfeld. "The Board is going to be much more strict in its approval of foreign medical schools.

"All things being equal, we have generally given foreign programs the benefit of the doubt," he says. "We're no longer prepared to do that."

He says he thinks his middle European upbringing has provided a helpful perspective on his life.

"Perhaps it suggests to me a lot of problems can be resolved by a little common courtesy, by observing the proprieties at all times," he reflects. "Many of the problems which confront us seem very trivial when people of good will can sit down and discuss them openly and honestly."

Reflecting for a moment, he added with a smile, "One of the triumphs of my academic career is that I can string together endless cliches at a moment's notice."

Nevertheless, he said with unmistakable sincerity that he feels privileged in his new position, and is looking forward to the job ahead. He also said he is impressed with the caliber and dedication of the employees in the Department of Licensing and Regulation.

"That has been a major discovery for me," he said from his warm, sunny office. "They work very hard."☐

By Sheri Greenhoe, Managing Editor

Physicians must keep CME records

Every three years, in order to renew their medical licenses, Michigan physicians must document that they have earned 150 hours of continuing medical education (CME) credits. At least 75 of those credits must be earned in Category I. Individual physicians are responsible for keeping thorough records of their own CME activities over a four year period.

MSMS has developed a handy CME record-keeping folder that is available to members at no charge. All members received one inside the January 30 *Medigram*. Contact MSMS headquarters for additional copies.

CME requirements

It is important that doctors realize that only participation in *accredited* courses will satisfy relicensure requirements. (See the list of accredited CME sponsors on page 232.) Accreditation is just one part of a complicated process at national, state and local levels to ensure that patients receive the best care that the art and science of medicine can offer.

In Michigan, the legislature established the law requiring CME for relicensure, the Board of Medicine enforces it, and the MSMS Committee on CME Accreditation establishes criteria and standards, based on national standards, for Michigan programs.

For-credit opportunities

MSMS has become increasingly active in the education of physicians and allied health professionals. More than 1,400 physicians and up to 1,000 nurses, students, technicians, coaches, trainers and others attended three major MSMS conferences in 1985: the Annual Scientific Meeting; the Michigan Conference on Maternal and Perinatal Health, and the MSMS Sports Medicine Conference. Physicians earned more than 10,000 hours of Category I credit at these three conferences alone.

Eighteen MSMS co-sponsored programs attracted 600 physicians who earned, collectively, 4,200 credit hours. As the body of medical knowledge expands, so does the range of MSMS continuing medical education opportunities. Look for more hands-on instruction and teleconferences in the near future.☐

CME leaders learn new guidelines

More than 80 physician CME leaders, educators and administrative assistants from Michigan hospitals and organizations accredited as CME providers attended a March 6 MSMS conference. "The New Essentials for CME Accreditation: Does Your CME Program Meet Them?" was the title of the program held at the Kellogg Center, East Lansing.

Donald J. Aiken, MD, chairman, Committee on Continuing Medical Education Accreditation, opened the conference designed to explain the new Essentials, or criteria, by which eligible CME sponsors are evaluated.

Grosse Pointe physician Mark Kolins, MD, a Committee member, above left, asked questions during one of six breakout sessions. The sessions gave participants an opportunity to share practical ideas. Michael W. Radke, PhD, Committee member, far right, led a discussion about implementation.

See next page for a complete list of accredited organizations ➡

The following have been accredited by the MSMS Committee on CME Accreditation to provide Category I CME programming in Michigan. Only Category I CME activities sponsored or joint-sponsored by these accredited hospitals and organizations (or hospitals and organizations accredited by the Accreditation Council for Continuing Medical Education) are accepted by the Michigan Board of Medicine towards the requirements for Michigan relicensure.

Hospitals:

Annapolis Hospital, Wayne
Bay Medical Education, Bay City
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Medical Center, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Branch County Community Health Center, Coldwater
Burns Clinic Medical Center, Petoskey
Butterworth Hospital, Grand Rapids
Catherine McAuley Health Center, Ann Arbor
Center for Forensic Psychiatry, Ann Arbor
Central Michigan Community Hospital, Mt. Pleasant
Chippewa County War Memorial Hospital, Sault Ste. Marie
Community/Leila Hospitals, Battle Creek
Cottage Hospital, Grosse Pointe
Crittenton Hospital, Rochester
Detroit-Macomb Hospital Corporation, Detroit
Dickinson County Memorial Hospital, Iron Mountain
Edward W. Sparrow Hospital, Lansing
Ferguson Hospital, Grand Rapids
Francis A. Bell Memorial Hospital, Ishpeming
Grace Hospital, Detroit
Gratiot Community Hospital, Alma
Hawthorn Center, Northville
Henry Ford Hospital, Detroit
Heritage Hospital, Taylor
Herrick Memorial Hospital, Tecumseh
Holy Cross Hospital, Detroit
Hurley Hospital, Flint
Huron Memorial Hospital, Bad Axe
Ingham Medical Center, Lansing
Kalamazoo Regional Psychiatric Hospital, Kalamazoo
K. I. Sawyer USAF Hospital, K. I. Sawyer AFB
Lakeshore Continuing Medical Education, Muskegon
Marquette General Hospital, Marquette
McLaren General Hospital, Flint
Mecosta County General Hospital, Big Rapids
Mercy Hospital, Port Huron
Midland Hospital Center, Midland
Mt. Carmel Mercy Hospital and Medical Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Northville Regional Psychiatric Hospital, Northville
Oakland Health Education Program, Rochester
Oakwood Hospital, Dearborn
Outer Drive Hospital, Lincoln Park
Pennock Hospital, Hastings
Pontiac General Hospital, Pontiac
Port Huron Hospital, Port Huron
Portage View Hospital, Hancock
Providence Hospital, Southfield
Saginaw Cooperative Hospitals, Saginaw
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Hospital, Mt. Clemens
St. Joseph Mercy Hospital, Pontiac
St. Lawrence Hospital, Lansing
St. Mary Hospital, Livonia
St. Mary's Hospital, Grand Rapids
Saline Community Hospital, Saline
Saratoga General Hospital, Detroit
Sinai Hospital of Detroit, Detroit
Southwestern Michigan Area Health Education, Kalamazoo
Traverse City Regional Psychiatric Hospital, Traverse City
VA Medical Center, Battle Creek
VA Medical Center, Iron Mountain
W. A. Foote Memorial Hospital, Jackson
William Beaumont Hospital, Royal Oak
Ypsilanti Regional Psychiatric Hospital, Ypsilanti

Organizations:

American Academy of Pediatrics, Troy
American Cancer Society, Lansing
American Heart Association of Michigan, Southfield
American Lung Association of Michigan, Lansing
Ann Arbor Psychiatric Association, Ann Arbor
Center for Human Resource Development—Michigan Department of Mental Health, Lansing
Michigan Academy of Family Physicians, Lansing
Michigan Dermatological Society, Royal Oak
Michigan Ophthalmological Society, Harper Woods
Michigan Psychoanalytic Institute, Southfield
Michigan Psychoanalytic Society, Southfield
Michigan Society of Anesthesiologists, East Lansing
Michigan State Medical Society, East Lansing
Public Health Consortium, Ann Arbor
Upjohn Company, Kalamazoo
Warner-Lambert Company, Ann Arbor ☐

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May 1986

Reye's Syndrome update

Since the last update an additional case of Reye's Syndrome was reported. A one-year-old male from Tuscola County developed symptoms of Reye's Syndrome in early March following a gastrointestinal illness. This is only the second case of Reye's Syndrome reported in Michigan since April of 1985.

Influenza activity in Michigan has declined considerably. Based on school children reported absent with influenza-like illness the peak of this year's outbreak appears to have been mid February.

Promise of AIDS cure hampers prevention

Premature talk of a vaccine for AIDS has hampered efforts to control the epidemic by persuading high risk groups to alter their sexual habits, according to a University of Michigan expert.

"The ongoing epidemic of smoking has taught us that prevention as a strategy is particularly hard to sell as long as treatment and cure are bandied about as alternatives," said June Osborn, MD, dean of U-M's School of Public Health.

Transmission of the disease should be relatively easy to arrest because the virus causing AIDS is, at present, difficult to transmit except by sexual routes, said Doctor Osborn, a viral disease specialist, consultant to the National Institutes of Health and the US Food and Drug Administration. She was recently appointed to two of the three committees named by the Institute of Medicine and the National Academy of Sciences to assess national strategies for AIDS research and health care.

"If we could put into action the knowledge we have gained from epidemiologic study, we could forecast an end to the trouble, or at least an end to the further spread of the virus," she said. But a number of obstacles have barred the way.

"The people at greatest risk of becoming infected—homosexual men—have been beleaguered by society to such an extent that they may evade or ignore the efforts to control the spread of AIDS," Osborn said.

"The members of the second highest risk group—intravenous drug abusers— have already said goodbye to caution . . . concerning their own salvation, let alone that of others."

Prevention efforts also have been hampered because public health officials have been reluctant to give explicit details about the sexual practices through which the disease is transmitted and which, if avoided, will eliminate the risk of AIDS.

"The very messages that we must broadcast in order to abort the epidemic and buy time for further scientific advancement require the use of words that are taboo in high places," Osborn said.

Public health officials are under pressure not to be explicit and not to "send out messages that even seem to condone sexual and other practices that deviate from a governmentally sanctioned norm.

"No official document should use the phrase "safe sex," even if that currently appears to be the major promising route to safety for an important segment of the population."

At the same time, published accounts of research toward developing a vaccine or treatment for the disease may be fueling false or distant hopes that further detract from efforts to modify the sexual behavior of high risk groups.

The virus that causes AIDS presents scientists with some unique challenges in trying to develop a vaccine. The virus fequently changes its external surface, enabling it to dodge conventional approaches to vaccination. Another problem is identifying antibodies that actually neutralize the virus.

"Even if a vaccine were at hand, the logistics of testing it would be hard to imagine," Osborn said. "In order to establish protective efficacy, one would need a group of willing, thoroughly informed research subjects at high risk but as yet unexposed.

"The slowness of the viral infection would make assessment of both efficacy and safety a tremendous challenge, and the liability problems would be vast. Who would want to manufacture such a vaccine? To whom would it be given? High-risk groups? The general public? If we can't cope with pertussis (whooping cough), how can we manage a vaccine for the AIDS virus?"

Osborn said the greatest hope for medical intervention, beyond prevention, lies in understanding the role of co-factors, such as other infections, drugs and lifestyle characteristics, that may determine whether an infected person becomes deathly ill or carries the virus without developing symptoms.

More than 17,000 cases of AIDS have been reported to the national Centers for Disease Control since the count began in 1981, and the number of new cases is doubling annually. More than 9,000 patients have died.

Government health officials also have estimated that another 930,000 Americans are infected but have not become ill.☐

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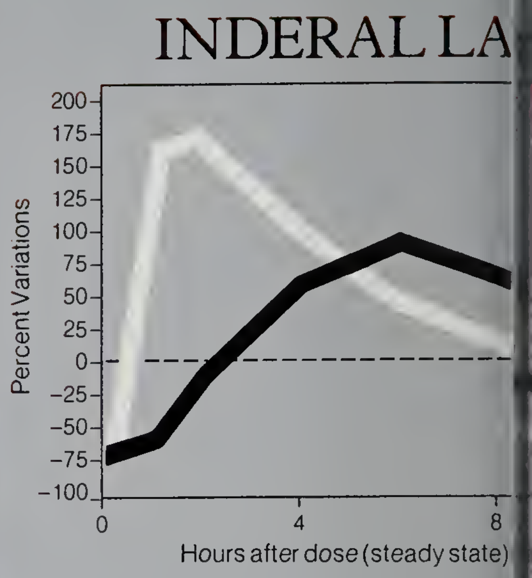

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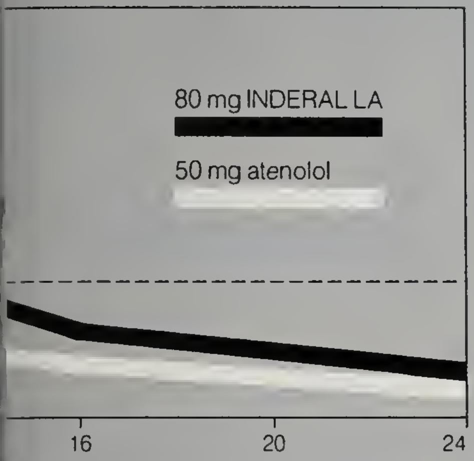

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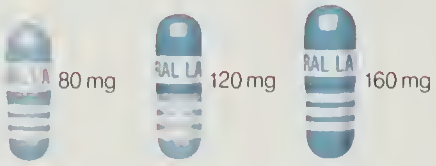

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CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL® LA): Propranolol is contraindicated in. 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs

WARNINGS

Propranolol hydrochloride (INDERAL® LA): CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or propranolol should be discontinued (gradually, if possible)

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction following *abrupt* discontinuance of propranolol therapy Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranclol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker In one case this resulted after an initial dose of 5 mg propranolol

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution, since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes In these patients, it may be more difficult to adjust the dosage of insulin Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease In patients with renal disease, thiazides may precipitate azotemia In patients with impaired renal function, cumulative effects of the drug may develop

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported

PRECAUTIONS

Propranolol hydrochloride (INDERAL® LA): GENERAL Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test Withdrawal may lead to a return of increased intraocular pressure

CLINICAL LABORATORY TESTS Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs, such as reserpine should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug induced toxicity There were no drug-related tumorigenic effects at any of the dosage levels Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug

PREGNANCY Pregnancy Category C Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

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Each capsule contains propranolol HCl (INDERAL® LA), 80 mg, 120 mg, or 160 mg, and hydrochlorothiazide, 50 mg

80/50
120/50
160/50

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NURSING MOTHERS Propranolol is excreted in human milk. Caution should be exercised wl propranolol is administered to a nursing mother

PEDIATRIC USE Safety and effectiveness in children have not been established

Hydrochlorothiazide: GENERAL. Periodic determination of serum electrolytes to de possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electro imbalance, namely Hyponatremia, hypochloremic alkalosis, and hypokalemia Serum and u electrolyte determinations are particularly important when the patient is vomiting excessivel receiving parenteral fluids. Medication such as digitalis may also influence serum electroly Warning signs irrespective of cause are: Dryness of mouth, thirst, weakness, lethargy, drowsin restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, gastrointestinal disturbances such as nausea and vomiting

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present during concomitant use of corticosteroids or ACTH

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hy kalemia can sensitize or exaggerate the response of the heart to the toxic effect of digi (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potass supplements, such as foods with a high potassium content

Any chloride deficit is generally mild and usually does not require specific treatment, exc under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may oc in edematous patients in hot weather, appropriate therapy is water restriction, rather than admi tration of salt, except in rare instances when the hyponatremia is life-threatening In actual depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thia therapy

Insulin requirements in diabetic patients may be increased, decreased, or unchanged Diab mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diur therapy

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides Pathologic changes in the parathyroid gland hypercalcemia and hypophosphatemia have been observed in a few patients on prolon thiazide therapy The common complications of hyperparathyroidism, such as renal lithiasis, b resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued be carrying out tests for parathyroid function

DRUG INTERACTIONS: Thiazide drugs may increase the responsiveness to tubocurarine

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy pati Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not suffic to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY Pregnancy Category C. Thiazides cross the placental barrier and appear in c blood The use of thiazides in pregnancy requires that the anticipated benefit be weighed aga possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytope and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS: Thiazides appear in human milk. If use of the drug is deemed esser the patient should stop nursing

PEDIATRIC USE Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL® LA): Most adverse effects have been mild transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotens paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Rayn type.

Central Nervous System. Lightheadedness; mental depression manifested by insom lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, vi disturbances; hallucinations, an acute reversible syndrome characterized by disorientatior time and place; short-term memory loss, emotional lability; slightly clouded sensorium; decreased performance on neuropsychometrics.

Gastrointestinal. Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, co pation, mesenteric arterial thrombosis; ischemic colitis

Allergic. Pharyngitis and agranulocytosis; erythematous rash; fever combined with aching sore throat; laryngospasm and respiratory distress.

Respiratory: Bronchospasm

Hematologic. Agranulocytosis; nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reporte

Miscellaneous. Alopecia, LE-like reactions; psoriasiform rashes; dry eyes; male impotence, Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the serous membranes, and conjunctivae reported for a beta blocker (practofol) have not b associated with propranolol

Hydrochlorothiazide:

Gastrointestinal: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipa jaundice (intrahepatic cholestatic jaundice), pancreatitis; sialadenitis

Central Nervous System. Dizziness, vertigo; paresthesias; headache; xanthopsia.

Hematologic: Leukopenia, agranulocytosis; thrombocytopenia; aplastic anemia.

Cardiovascular: Orthostatic hypotension (may be aggravated by alcohol, barbiturates narcotics).

Hypersensitivity Purpura, photosensitivity; rash; urticaria; necrotizing angiitis (vascu cutaneous vasculitis), fever; respiratory distress, including pneumonitis; anaphylactic reactior

Other. Hyperglycemia, glycosuria, hyperuricemia, muscle spasm; weakness; restlessn transient blurred vision

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduce therapy withdrawn.

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1. Data on file, Ayerst Laboratories. **2.** Ravid M, Lang R, Jutrin I The relative antihyperter potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily *Arch Intern* 1985;145:1321-1323 **3.** Sumiye L, Vivian AS, Frisof KB, et al: Potassium loss associated hydrochlorothiazide versus chlorthalidone. *Clin Ther* 1981,4 308-320. **4.** Ram CVS, Garrett Kaplan NM Moderate sodium restriction and various diuretics in the treatment of hyperten *Arch Intern Med* 1981,141 1015-1019

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By Joel I. Hamburger, MD

Doctors as purveyors of health insurance?

It may be said that the advent of health insurance was the beginning of the debasement of an ancient and honorable profession. Physicians were no longer the guardians of their patients' health, but instead became businessmen concerned with and motivated by profits. Some will object to the foregoing, and rightly note that most physicians still serve the public with the dedication and selflessness of their predecessors. As much as physicians might like to believe that this is the image projected by the medical profession, we must admit that large segments of the public do not see things that way. Our status would seem to be defined in large measure by the conduct of the least of us. This too is reasonable, for have we not so often said, "We police ourselves"?

The concept that many physicians are motivated primarily by cupidity is surely one that underlies much of the impetus for the exploration for, and implementation of alternative systems for the delivery of health care that are not based upon the traditional concept of fee-for-service. There is the decided presumption that fee-for-service provides an irresistible incentive for the provision of unnecessary services for profiteering, especially when insurance companies relieve patients from concern for the costs of medical care. Can we deny that many physicians have taken advantage of the fee-for-service system to enrich themselves by the provision of unnecessary services? Can we deny that our claim that we police ourselves (through our medical societies) to protect the public from unscrupulous practitioners is only a pious slogan?

"Risk-taking in the hope of profits is the business of the insurance industry."

Having said all this, it can also be said that, even though the abuse of fee-for-service has the potential to enrich doctors, adherence to ethical principles, and practicing medicine with a legitimate concern for patient needs would not impoverish physicians. Honest physicians make good livings in a fee-for-service system.

Those who abuse it do so not out of personal need, but only by reason of greed. It is the insurance carriers that take the economic risks in the provision of health care. If the premiums they collect are insufficient to cover their expenditures, they can suffer a loss, even the possibility of bankruptcy. These carriers also have the potential for profit if they control their costs while maintaining high charges. Risk-taking in the hope of profits is the business of the insurance industry. Should it be the business of physicians? HMOs make it so.

A sure thing

HMOs pay physicians, or groups of physicians, set fees for total patient care (or some variation thereof). The physicians must then pay for the medical expenses of their patients, hoping that what they receive will be more than what they pay out. Thus the insurance company underwriting an HMO is relieved of the element of risk that is the essence of the insurance industry. The insurance company now has a sure thing. It simply marks up what it pays to the HMO by whatever the market will bear, sells the contract to businesses that wish to provide health insurance for their employees, and pockets the risk-free profits. The HMO, i.e. its physicians, now assumes the risk-taking function that is the reason for the existence of the insurance industry.

In fee-for-service, physicians can profiteer, but they cannot suffer bankruptcy, and there is no reason to deny patients access to needed care. The potential for HMO profits is strictly limited by the payments they receive from the insurance carriers. In HMOs physicians can profiteer only by denying patients the care they need. However, the risk of losses is unlimited, especially if a high level of care is rendered, or, if by chance, a disproportionate number of pa-

Continued on page 240

Doctor Hamburger is a Southfield internist.

tients require intensive care. That insolvency is more than a theoretical risk is shown by the large number of HMOs that have failed.

How will prudent physicians act in such a system? Worse yet, how will those who are motivated by cupidity act? What experience has prepared the physician to deal with a system in which there is a clear-cut conflict of interest between the provision of health care services to his patients, and his own economic welfare?

Not a solution

HMOs are not a solution to the high cost of health care; they just create an economic incentive to withhold necessary medical care. Why would any physician want to be the guarantor of the costs of medical care for his patients? Physicians may be afraid not to participate in HMOs lest they lose patients (i.e. income) to other physicians who do participate. Is this fear realistic? After all, we physicians stand together, don't we? Didn't our march on Lansing demonstrate our solidarity? Or was that march only an example of solidarity on the cheap? We sacrificed one day's income (not even that for salaried physicians, or those in groups), even though we were not prepared to take the solidarity plunge and just say NO! No, we will not participate in schemes designed to compromise the quality of medical care. It is the responsibility of our leaders to lead us to stand up for what we know is right, and not to acquiesce in every hair-brained notion that comes along out of fear that otherwise we might be accused of resisting progress.

We are doctors. We should practice medicine. We should not be used by others to become substitute purveyors of health insurance.☐

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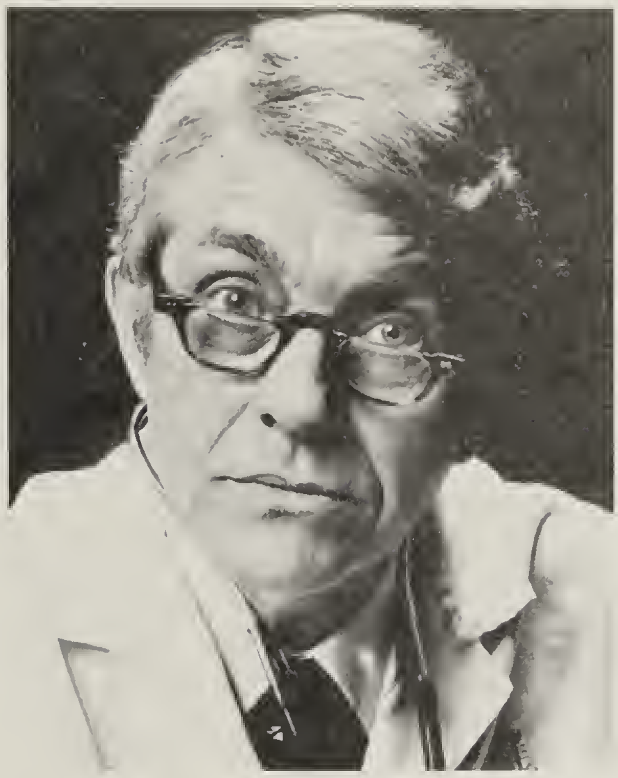

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By Katharine S. Brown

Jointly held property has pluses and minuses

Photo by Spangenberg/Bitzinger

Many married couples have an inclination to hold various forms of property jointly. They feel a distinct emotional preference for joint ownership; it seems to reflect their attitude toward their relationship. Common ownership manifests a willingness to share and evokes mutual trust. In addition to these real, but not very tangible advantages, there is also a generally held belief that joint ownership will save taxes and reduce costs. Unfortunately, in many cases, the actual result may be just the opposite: increased taxes and increased costs.

Ms. Brown is vice president of Prescott, Ball and Turben, Inc., East Lansing.

Advantages

Joint ownership can provide couples with real benefits, especially where their combined estate is modest:

- Avoidance of probate
- Ease of transfer of title to survivor
- Ready access to assets either by spouse during life, or by survivor
- Possible protections from the separate creditors of either spouse
- Psychological and emotional comfort

Certain assets are especially appropriate for joint ownership. It usually makes sense, for instance, that a married couple have at least a modest joint checking or savings account with right of survivorship. This can be used to provide the survivor with immediate cash for support, payments of funeral expenses and other items requiring prompt

Continued on page 244

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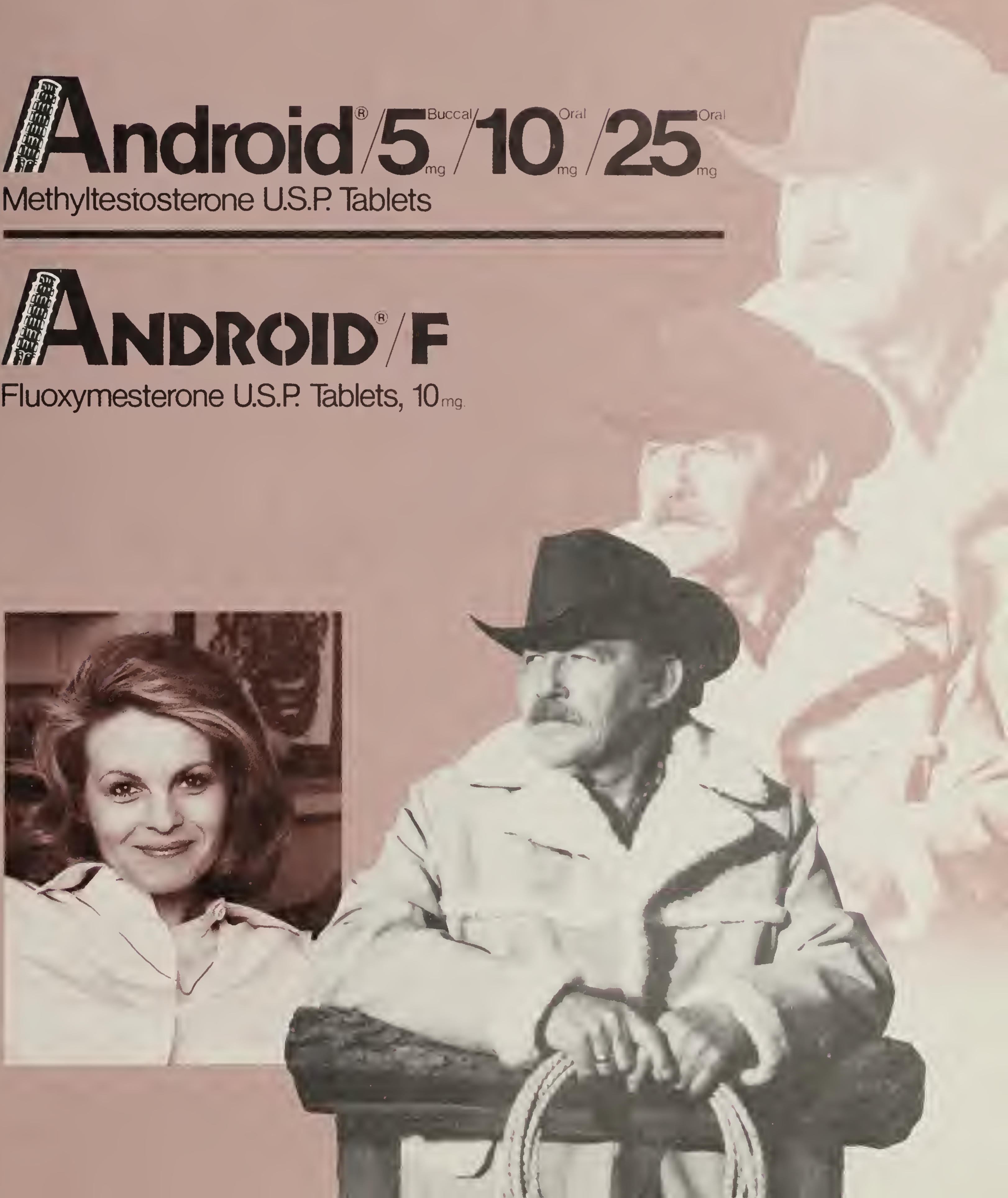


settlement. For many spouses, common ownership of their home is very important. But as attractive as all these advantages seem, there are additional factors to be considered.

Drawbacks

For estate planning purposes, joint ownership is generally undesirable. This is especially true where the combined estates are substantial. Most importantly, joint tenancy does not eliminate estate tax. In fact, it may serve only to increase the tax bite.

This possible estate settlement disadvantage to joint ownership assumes survivor rights, and is a direct result of the 1981 tax law. First, that law eliminated federal tax on property transfers between married spouses. Thus, whether ownership passes by gift, title or will, there is no federal tax. Second, a credit that can be used to offset taxes due on transfers to persons other than a spouse was established. This credit permits transfers of amounts from $400,000 in 1985, to $600,000 in 1987, without tax payment.

To take advantage of this "tax-free" transfer, most estate planners recommend that a trust be established upon the death of the first spouse to receive the maximum permitted amount ($400,000 to $600,000). Amounts in excess of this transfer tax-free to the surviving spouse and are included in the survivor's estate, which thus avoids the trust assets. The result is a possibility of no federal tax on estates of $800,000 to $1,200,000, depending upon the year of death. Such Unified Credit Trusts, as they are called, usually provide for income to the surviving spouse for life. Then the principal goes to the couple's children.

The ironic part is that though your estate plan may provide for this tax-saving procedure, unless each spouse has individual ownership of assets (not joint with survivor rights) much of the benefit may be lost. Joint tenancy rights of survivorship result in the survivor owning the assets, regardless of what his, or her, will states. I often find that most assets women hold are jointly held with their husbands, and thus may not qualify for use in funding a "credit" trust.

"Joint ownership, even with your spouse, is discouraged and alternatives should be investigated."

I urge you to review your own estate in light of your asset ownership. There are further drawbacks in placing property in joint ownership:

- Loss of control (must act jointly)
- Loss of income (must share)
- Loss of the power to dispose (must have co-owner's consent)
- Possible management problems for the survivor
- Legal uncertainties involving incompetence and marriage difficulties
- Need for will remains, in order to dispose of other, not joint property
- Possible problems relating to termination of joint tenancy

Nonspouse joint owners

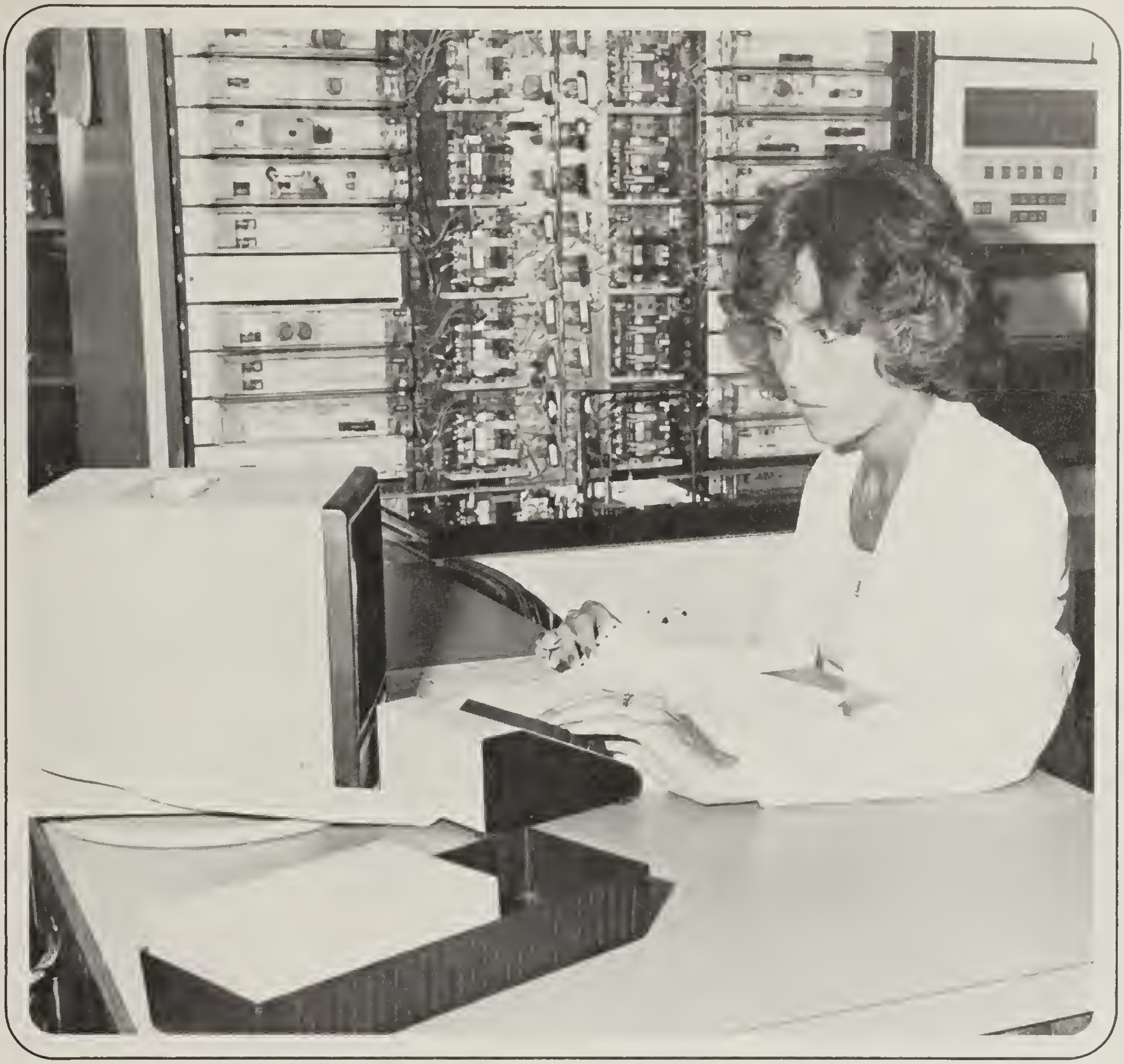
An older parent often seeks joint ownership of assets with a child. This procedure does gain all the benefits previously discussed, but it gains all the disadvantages, too. Remember too, joint tenancy does not avoid estate taxes. In addition, there are special problems. For instance, technically the income from joint investment should go to each owner according to his/her interest. This can present both problems and benefits. However, practically, the payor of the income may prefer to report the income using only one social security number. Another problem involves the allocation of capital gains.

Estate settlement

When the joint owners are married spouses, the rule is that one-half of all joint property is included in the estate of the first to die. That one-half receives "stepped-up" basis (cost is changed from original cost to current value). For nonspouse joint owners, the full value of the joint property is included in the estate of the first to die, unless contribution by the survivor can be proved. Again, the portion of the property included in the descendant's estate received "stepped-up" basis.

Conclusion

In spite of the advantages, except for the more modest estates, joint ownership, even with your spouse, is discouraged and alternatives should be investigated. A revocable trust, for example, can be set up to provide the survivorship feature, avoid probate and supply your spouse with immediate cash, while at the same time permitting you to retain control and have the use of the property during your lifetime. Finally, where joint tenancies between spouses exist and it is deemed advisable to terminate that form of ownership, the unlimited marital deduction provision makes it possible to vest entire ownership in one spouse without gift tax.☐



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Michigan Conference on Maternal and Perinatal Health celebrates 25th year

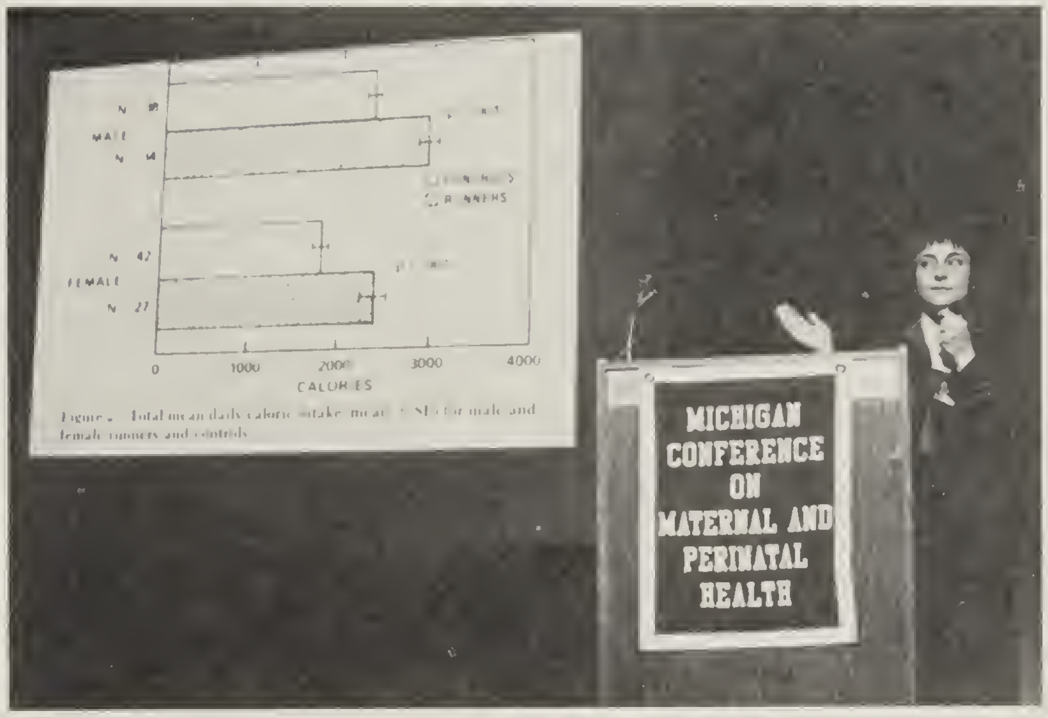
MICHIGAN
CONFERENCE

Richard J. McMurray, MD, Flint Ob/Gyn and MSMS president, welcomed more than 700 physicians, nurses and allied health professionals to the 25th Michigan Conference on Maternal and Perinatal Health. He shared with the audience a photograph of the key people involved in the Clara Elizabeth Fund, a Flint-born predecessor of today's statewide maternal health network.

Ann E. Swinford, MD, genetics counselor, MSU Department of Pediatrics and Human Development, right, answers a question about her presentation on maternal age.

Harvey Day, PhD, is executive vice president and chief operating officer at Michigan Health Care Corporation, Detroit. "We need this celebration," he observed, in light of the health care delivery and liability problems practitioners now face. He called the gathering "an outstanding testament to interdisciplinary work," and predicted the next 25 years would be as significant as the last had been in terms of technology and medical progress.

The topic "Planning for Pregnancy" is essential, and fills a gap in ob/gyn care, said Kenneth J. VanderKolk, MD, director of ob/gyn education at Butterworth Hospital, Grand Rapids, and professor at MSU's College of Human Medicine. "We forget the one million women who want a baby," he said, as health care providers tend to concentrate on the three million with unplanned or unwanted pregnancies.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MICHIGAN CONFERENCE ON MATERNAL AND PERINATAL HEALTH

Mona Shangold, MD, FACOG, is assistant professor, Department of Ob/Gyn, and director of the Sports Gynecology Center at Georgetown University School of Medicine. She discussed nutrition and the causes, effects and prevention of osteoporosis.

Michael Katz, MD, left, is assistant professor, Department of Ob/Gyn at Children's Hospital and the University of California, San Francisco. He told the audience that "preterm labor is not uterine activity or cervical changes — it has to be both." Women with frequent uterine activity throughout pregnancy are more likely candidates for pre-term labor, he said, and he discussed the value of ambulatory monitoring.

MSMS Hospital Medical Staff Section holds second annual meeting

harma
MICHIGAN STATE MEDICAL SOCIETY
Conway
Woodl

Sixteen resolutions calling for actions on issues including risk management, Blue Cross Blue Shield of Michigan documentation requirements and the availability of malpractice insurance, were submitted to the March 11 meeting of the MSMS Hospital Medical Staff Section in Livonia. Gerald Conway, MD, William Beaumont Hospital, above, chaired a reference committee hearing.

EDICAL
DUHA

Richard Thompson, MD, a national expert on medical staff issues, was keynote speaker. Doctor Thompson, from Elmhurst, Illinois, outlined methods for creating effective medical staff organizations and mechanisms for reducing the risks of lawsuits.

Michael Parks, MD, South Haven Community Hospital, a reference committee member, listens to testimony on a resolution calling for an assessment of the public image of physicians.

Peter Duhamel, MD, Chairman of the MSMS Hospital Medical Staff Section, right, and Gary Maynard, MD, HMSS vice chairman, talk about Doctor Duhamel's candidacy for At-Large Member to the AMA HMSS Governing Council.

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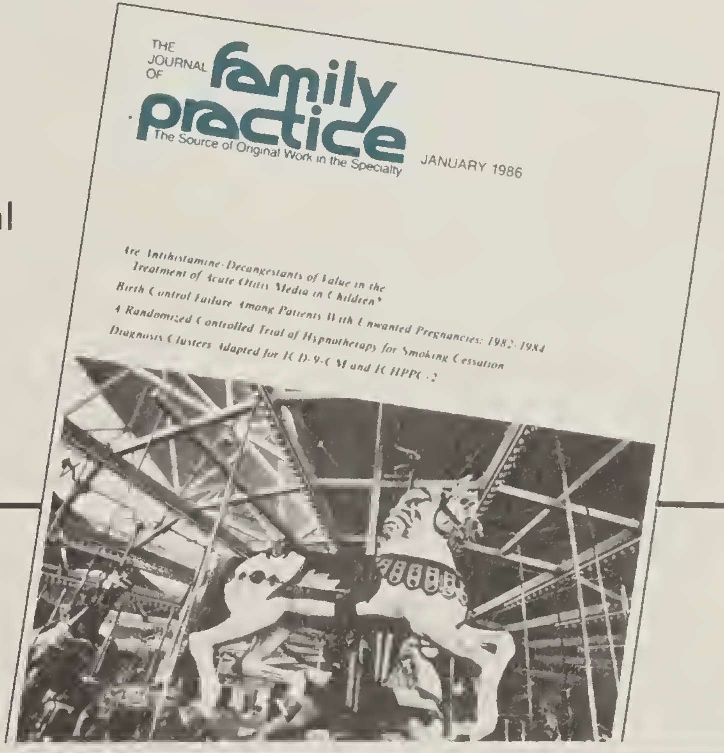

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Are Antihistamine-Decongestants of Value in the Treatment of Acute Otitis Media in Children?
Birth Control Failure Among Patients With Unwanted Pregnancies: 1982-1984
A Randomized Controlled Trial of Hypnotherapy for Smoking Cessation
Diagnosis Clusters Adapted for ICD-9-CM and ICHPPC-2

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By Nancy Cranda

AMPAC's Campaign Manager School requires a serious commitment

One recent Sunday morning I found myself flying the "friendly skies" to Arlington, Virginia, for an AMPAC-sponsored Campaign Manager School. The course, the second AMPAC has held, is a five and one-half day intensive workshop, conducted by faculty from the Institute of Strategic Management, Leonard G. Hursch, PhD, director.

The purpose of the program is to train members of the medical community, physicians, spouses and friends of organized medicine in the methods of managing a political campaign. Participants study elements of political campaigning that include fundraising, the media, budgeting, volunteer coordination, political strategy and campaign theme development. AMPAC stresses that participation in the school requires a *serious* commitment, both during the week and after. It is advised that only those with time, specific intent and prior political experience attend.

My own participation stemmed from conversations with Kevin Kelly at MSMS and Jack Hitaling, AMPAC assistant director. My political experience includes two election campaigns of my own—I am currently serving a second four-year term on my local city council. And I had had volunteer involvement in other political campaigns. There is the possibility of a future campaign for other office for me

---

Mrs. Crandall, Norton Shores, is immediate past president, MSMS Auxiliary.

nd this school would be good reparation in that event.

Day One: I arrived in Vashington, DC at noon Sunay, and at the hotel in irginia in time to register and eceive a *huge* notebook and older packed with informaon. We began promptly at pm with a welcome by Peter auer, Executive Director of MPAC who introduced eonard Hirsch, Director of Initute Management and a wellnown Washington political onsultant. Doctor Hirsch utlined the program, gave an verview of our activities for ne week, and laid some round rules. Then he introuced Wilma Goldstein, director of survey research for the ational Republican Commitee, and Joel Bradshaw, olitical consultant for the emocratic National Commitee. We were divided into nall groups to get acuainted.

There were 45 participants: hree physicians, 23 Auxilians, everal PAC staff people, everal who are employed by egislators on their staffs, and ledical Society staff members. len and women and a wide inge of age and political exerience were represented.

oles and responsibilities

We heard a description of e "campaign world" and bout the roles and responbilities of those involved. We eard a lecture on strategy, ne on polling, and after a eak for dinner, a talk on rgeting.

We were divided into four oups of eleven or twelve eople. It was explained that e were to conduct a camign using material given to about the District, the sults of a poll which had been conducted, and several other pieces of information describing the area and candidates. We were assigned to role play either a Republican incumbent or a Democratic challenger.

Our assignments were to take us, step-by-step, through a campaign ending with a presentation on Thursday morning. Critiques and grading would take place and the victor would be announced at dinner Thursday evening.

With an AMPAC staff person acting as facilitator, we adjourned to separate rooms with assignments to make a targeting plan, formulate a campaign strategy, and write a campaign announcement speech. We had to decide on duties and roles of each member of the group, and were given reading assignments each night which most never quite finished before falling into an exhausted sleep. Bedtime Sunday was 1am.

Day Two: On Monday morning the "candidates" presented practice speeches. Since I had become the candidate for our group—"Allen"—I unofficially declared my candidacy for the 3rd Congressional District of the State of Euphoria. Discussion of each of the speeches was followed by a lecture. Jay Bryant, a Washington media consultant, gave a highly entertaining talk on theme and message. The afternoon lessons centered on planning, tactics, and the management system, and included some role playing in a "staff meeting." After a break for dinner, we learned about scheduling and advance work, then divided into our groups for more work on our congressional campaign.

Day Three: Most of Tuesday was spent exploring the financial aspects of a campaign: the budget, fundraising, and a session on party financing and PACs by Mr. Lauer and Tom Nides from the Democratic Congressional Campaign Committee. Late afternoon and evening centered around field operation, technology and volunteers in a campaign. Then, on to more work developing a budget, cash flow plan and income plan.

Day Four: Wednesday morning Jill Buckley and Jay Bryant, media consultants, explored with us the roles of both paid and earned media in a campaign. We saw videotapes of several campaign ads and discussed details and reasons for what we were seeing. In the afternoon, we heard about voter contact and suggested "get out the vote" efforts.

William Sweeney, President of Washington Resources and Strategy, spoke to us about opposition research and how to use it. Mr. Sweeney had that day returned from the Philippines where he had been a part of an International Poll Watch effort during the presidential election. He was extremely informative as he described his experiences there.

Our group met all afternoon and all evening to finish our campaign plan. We had made some basic decisions about theme and strategy, then divided up to do our individual role assignments. Late in the evening, we regrouped to put it all together for our presentation. This session lasted until nearly 2am, at which time the hotel fire alarm sounded and we all adjourned to the hotel lobby. We cheered the firefighters as they made sure

Continued on next page

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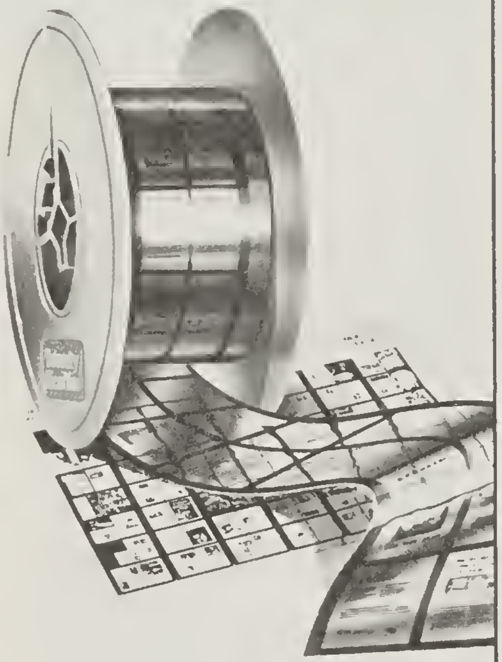

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"Allen for Congress" was the slogan campaign staffers used to try to elect Mrs. Crandall ("Allen") seated at center.

there was no fire anywhere. Most of us finally retired around 3am.

Day Five: Thursday—Election Day! Each group presented its campaign and explained how and why each part was done, including props, staging, humor, and anything else! Each was entertaining as well as instructive. This exercise took most of the day and included evaluations and voting.

Thursday evening AMPAC hosted a cocktail hour followed by the victory dinner. Each group was a winner in some category, and one group won the overall campaign—not ours, however!

Day Six: Friday morning we met to review the whole program. There was much discussion and some good suggestions were made. At intervals during the week, Doctor Hirsch had directed our attention to personal and group dynamics, and we continued to evaluate those processes. In a campaign, as in most endeavors, the interaction of the people i the group is vitally important.

After some closing remarks by our consultants and Pete Lauer, the conference officiall ended. Unofficially, many remained to say goodbye to new friends and acquaintances and to wish one another well in th campaigns that await us.

This was a unique experience, one that I am sure will be valuable to me. I enjoyed the people, the learning and am grateful to AMPAC an MDPAC for the opportunity to attend.☐

Editor's note: Just before pres time Mrs. Crandall, a Republican, announced her candidac for the 97th District Michigan House seat being vacated by Rep. Edgar A. Geerlings (R-Muskegon).

Board of Medicine actions

he following actions of the ichigan Board of Medicine vere taken following investigaive and appropriate action nd are reproduced verbatim rom summaries prepared by he Michigan Department of icensing and Regulation.

Name: Jacinto M. Anaya, MD
Action, Date Taken: Reprimand 1/20/86. **Reason:** Conviction of a misdemeanor reasonably related to and adversely affecting his ability to practice medicine in a safe and competent manner. (BC/BS fraud).

Name: Leroy Alcox, MD
Action, Date Taken: Summarily Suspended. February 19, 1986. **Reason:** Continued licensure constitutes an imminent threat to the public health, safety and welfare requiring emergency action.

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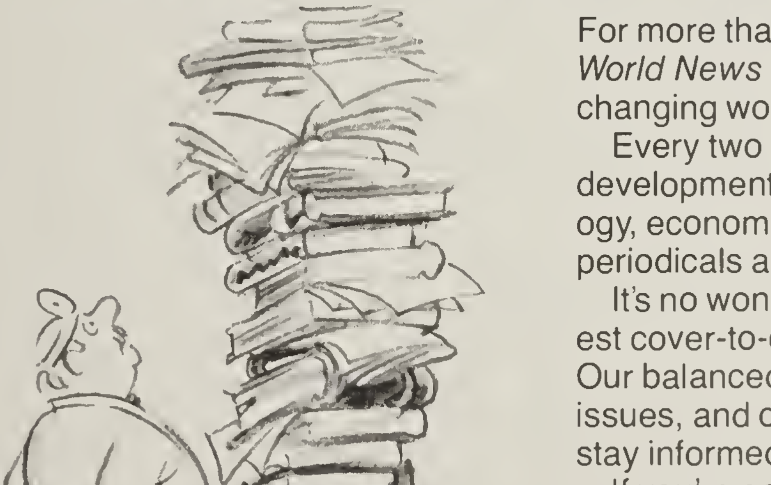

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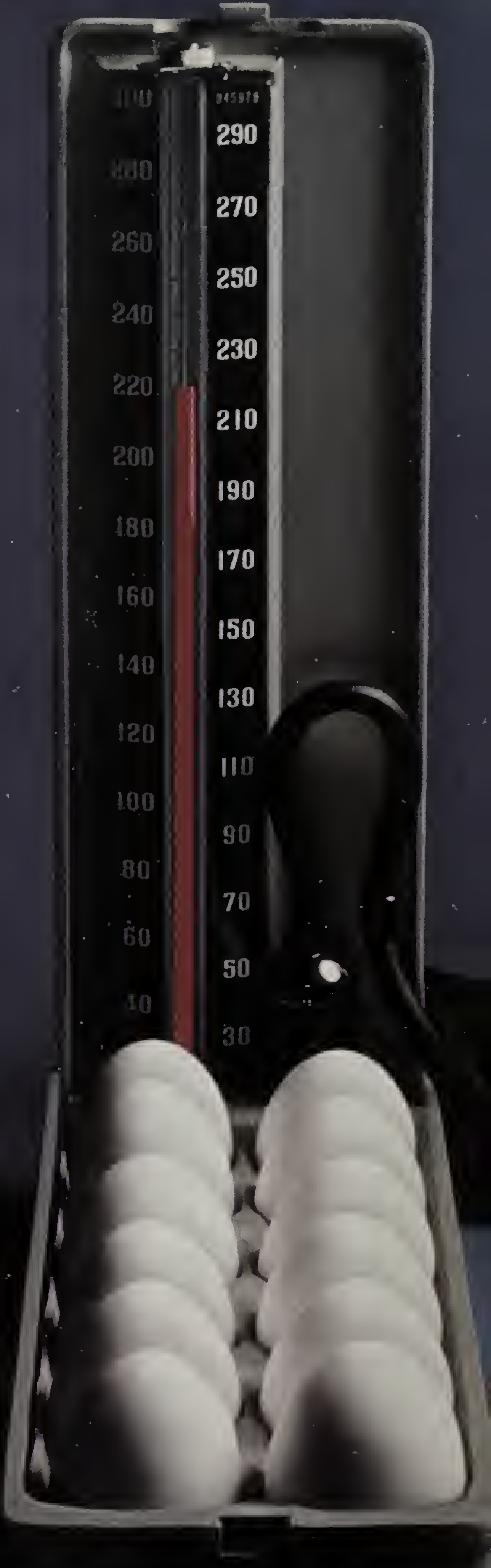
"High blood pressure should be a red flag to screen for cholesterol..."[1]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If your patients have hypertension, they probably have high cholesterol too.

The Framingham Heart Study[2] showed that over two thirds of the 35 and older population in that study with systolic blood pressures over 145 mmHg also had serum cholesterol levels of 225 mg/dL or more, and 46% had levels above 250 mg/dL.

While many clinical laboratories still report 250 mg/dL as "normal" cholesterol, the NIH Consensus Development Conference Statement on Cholesterol and Heart Disease[3] stated that any level above 220 mg/dL is associated with a significantly increased risk of coronary heart disease.

You need to know, because high cholesterol parallels high blood pressure as a CHD risk factor.

Epidemiological studies and large-scale prevention trials have indicated that as with blood pressure, serum cholesterol levels are proportionately related to CHD risk. Specifically, *"...for every 10 mmHg rise in pressure, there appears to be about a 30% rise in cardiovascular risk."*[4] *"...for every one percent you go up the American cholesterol scale, your subsequent rate of heart attack rises two to three percent."*[5]

And although the specific impact on CHD has not been determined, we know that many of the principal agents used to lower blood pressure actually increase cholesterol.

Wytensin® lowers blood pressure effectively without raising cholesterol.

While Wytensin is not a cholesterol-lowering agent and is not indicated for the treatment of hyperlipidemia, in controlled clinical trials[6] it caused a slight, sustained decrease in total cholesterol without reducing the HDL fraction or altering serum triglycerides.

At the same time, Wytensin lowered blood pressure as effectively as hydrochlorothiazide, propranolol, clonidine or methyldopa. Drowsiness and/or dry mouth, the most frequent side effects noted with Wytensin, usually diminish or disappear over time. In fact, in double-blind studies to date, discontinuance of therapy for all side effects occurred in about 13% of patients.

WyTensin®
(guanabenz acetate)

Antihypertensive therapy that does not increase cholesterol

See important information on following page.

References: 1. Glueck CJ: Remarks in the symposium, *Blood Pressure, Cholesterol and Coronary Heart Disease*, Washington, D.C., March 31, 1985. 2. *The Framingham Study, An epidemiological investigation of cardiovascular disease*, Section 28, U.S. Dept. of Health, Education, and Welfare. 3. National Institutes of Health Consensus Development Conference Statement, 1984: Vol 5, No 7, p 4. 4. Chobanian AV: The influence of hypertension and other hemodynamic factors in atherogenesis. *Progress in Cardiovascular Diseases, XXVI* (3): 177, Nov/Dec, 1983. 5. Castelli WP: Remarks in the symposium, *Blood Pressure, Cholesterol and Coronary Heart Disease*, Washington, D.C., March 31, 1985. 6. Data on file, Wyeth Laboratories.

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WyTensin®
(guanabenz acetate)

Antihypertensive therapy
that does not increase cholesterol

Brief Summary

Before prescribing, consult the complete package circular.

Indications and Usage: Treatment of hypertension, alone or in combination with a thiazide diuretic.

Contraindication: Known sensitivity to the drug.

Precautions: 1 Sedation: Causes sedation or drowsiness in a large fraction of patients. When used with centrally active depressants, e.g., phenothiazines, barbiturates and benzodiazepines, consider potential for additive sedative effects. 2 Patients with vascular insufficiency: Like other antihypertensives use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease, or severe hepatic or renal failure. 3 Rebound: Sudden cessation of therapy with central alpha agonists like **Wytensin** may rarely result in "overshoot" hypertension and more commonly produces increase in serum catecholamines and subjective symptomatology

INFORMATION FOR PATIENTS: Advise patients on **Wytensin** to exercise caution when operating dangerous machinery or motor vehicles until it is determined they do not become drowsy or dizzy Warn patients that tolerance for alcohol and other CNS depressants may be diminished. Advise patients not to discontinue therapy abruptly

LAB TESTS. In clinical trials, no clinically significant lab test abnormalities were identified during acute or chronic therapy Tests included CBC, urinalysis, electrolytes, SGOT, bilirubin, alkaline phosphatase, uric acid, BUN, creatinine, glucose, calcium, phosphorus, total protein, and Coombs' test. During long-term use there was small decrease in serum cholesterol and total triglycerides without change in high-density lipoprotein fraction In rare instances occasional nonprogressive increase in liver enzymes was observed, but no clinical evidence of hepatic disease

DRUG INTERACTIONS **Wytensin** was not demonstrated to cause drug interactions when given with other drugs, e.g., digitalis, diuretics, analgesics, anxiolytics, and antiinflammatory or antiinfective agents, in clinical trials. However, potential for increased sedation when given concomitantly with CNS depressants should be noted

DRUG/LAB TEST INTERACTIONS No lab test abnormalities were identified with **Wytensin** use

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. No evidence of carcinogenic potential emerged in rats during a two-year oral study with **Wytensin** at up to 9.5 mg/kg/day, i.e., about 10 times maximum recommended human dose In the Salmonella microsome mutagenicity (Ames) test system, **Wytensin** at 200-500 mcg per plate or at 30-50 mcg/ml in suspension gave dose-related increases in number of mutants in one (TA 1537) of five *Salmonella typhimurium* strains with or without inclusion of rat liver microsomes No mutagenic activity was seen at doses up to those which inhibit growth in the eukaryotic microorganism, *Schizosaccharomyces pombe*, or in Chinese hamster ovary cells at doses up to those lethal to the cells in culture. In another eukaryotic system, *Saccharomyces cerevisiae*, **Wytensin** produced no activity in an assay measuring induction of repairable DNA damage. Reproductive studies showed a decreased pregnancy rate in rats given high oral doses (9.6 mg/kg), suggesting impairment of fertility Fertility of treated males (9.6 mg/kg) may also have been affected, as suggested by decreased pregnancy rate of mates, even though females received drug only during last third of pregnancy

PREGNANCY Pregnancy Category C: WYTENSIN® MAY HAVE ADVERSE EFFECTS ON FETUS WHEN ADMINISTERED TO PREGNANT WOMEN. A teratology study in mice indicated possible increase in skeletal abnormalities when **Wytensin** is given orally at doses 3 to 6 times maximum recommended human dose of 1.0 mg/kg These abnormalities, principally costal and vertebral, were not noted in similar studies in rats and rabbits However, increased fetal loss has been observed after oral **Wytensin** given to pregnant rats (14 mg/kg) and rabbits (20 mg/kg) Reproductive studies in rats have shown slightly decreased live-birth indices, decreased fetal survival rate, and decreased pup body weight at oral doses of 6.4 and 9.6 mg/kg There are no adequate, well-controlled studies in pregnant women **Wytensin** should be used during pregnancy only if potential benefit justifies potential risk to fetus

NURSING MOTHERS Because no information is available on **Wytensin** excretion in human milk, it should not be given to nursing mothers.

PEDIATRIC USE Safety and effectiveness in children less than 12 years of age have not been demonstrated, use in this age group cannot be recommended

Adverse Reactions: Incidence of adverse effects was ascertained from controlled clinical studies in U.S. and is based on data from 859 patients on **Wytensin** for up to 3 years There is some evidence that side effects are dose-related Following table shows incidence of adverse effects in at least 5% of patients in study comparing **Wytensin** to placebo, at starting dose of 8 mg b.i.d.

Adverse Effect	Placebo (%) n = 102	**Wytensin** (%) n = 109
Dry mouth	7	28
Drowsiness or sedation	12	39
Dizziness	7	17
Weakness	7	10
Headache	6	5

In other controlled clinical trials at starting dose of 16 mg/day in 476 patients, incidence of dry mouth was slightly higher (38%) and dizziness was slightly lower (12%), but incidence of most frequent adverse effects was similar to placebo-controlled trial Although these side effects were not serious, they led to discontinuation of treatment about 15% of the time. In more recent studies using an initial dose of 8 mg/day in 274 patients, incidence of drowsiness or sedation was lower, about 20% Other adverse effects reported during clinical trials but not clearly distinguishable from placebo effects and occurring with frequency of 3% or less Cardiovascular—chest pain, edema, arrhythmias, palpitations. Gastrointestinal—nausea, epigastric pain, diarrhea, vomiting, constipation, abdominal discomfort. Central nervous system—anxiety, ataxia, depression, sleep disturbances ENT disorders—nasal congestion Eye disorders—blurring of vision Musculoskeletal—aches in extremities, muscle aches Respiratory—dyspnea Dermatologic—rash, pruritus Urogenital—urinary frequency, disturbances of sexual function Other—gynecomastia, taste disorders

Drug Abuse and Dependence: No dependence or abuse has been reported.

Overdosage: Accidental ingestion caused hypotension, somnolence, lethargy, irritability, miosis, and bradycardia in two children aged one and three years. Gastric lavage and pressor substances, fluids, and oral activated charcoal resulted in complete and uneventful recovery within 12 hours in both Since experience with accidental overdosage is limited, suggested treatment is mainly supportive while drug is being eliminated and until patient is no longer symptomatic Vital signs and fluid balance should be carefully monitored. Adequate airway should be maintained and, if indicated, assisted respiration instituted No data are available on **Wytensin** dialyzability

Dosage and Administration: Individualize dosage. A starting dose of 4 mg b.i.d. is recommended, whether used alone or with a thiazide diuretic Dosage may be increased in increments of 4 to 8 mg/day every one to two weeks, depending on response Maximum dose studied has been 32 mg b.i.d., but doses this high are rarely needed.

How Supplied: (guanabenz acetate) Tablets, 4 mg, bottles of 100 and 500; 8 mg and 16 mg, bottles of 100

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4. I gave six months ago.
5. I just got back from Monaco.
6. The lines are thirteen blocks long.
7. My mother won't let me.
8. I didn't sign up.
9. I'm going out of town.
10. Asthma runs in my family.
11. I forgot to eat this morning.
12. I'm allergic to flowering magnolia."

Each one's a doozy,
but we're hoping you
won't use any of them.
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Please, don't chicken out.

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Give your angina patient added protection...

CARDIZEM®: FEWER SIDE EFFECTS

diltiazem HCl/Marion

- **The lowest incidence of side effects among the calcium channel blockers[1]**
- **An exceptionally safe choice for angina patients with coexisting hypertension, diabetes, asthma, or COPD[1-3]**
- **Proven efficacy when used alone in angina[1, 4-6]**
- **Compatible with both beta-blockers and nitrates[7]**

Please see brief summary of prescribing information on the next page.

CARDIZEM® 60 mg tid or qid

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FEWER SIDE EFFECTS IN ANTIANGINAL THERAPY

BRIEF SUMMARY

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist).

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic)

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0 48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality These doses, in some studies, have been reported to cause skeletal abnormalities In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM (diltiazem hydrochloride) in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman it the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established The most common occurrences, as well as their frequency of presentation, are edema (2.4%), headache (2.1%), nausea (1 9%), dizziness (1.5%), rash (1 3%), asthenia (1 2%), AV block (1 1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia
Gastrointestinal	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic	Pruritus, petechiae, urticaria, photosensitivity
Other.	Polyuria, nocturia

The following additional experiences have been noted

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM. erythema multiforme, leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered

Bradycardia	Administer atropine (0 60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy
2. **Prophylactic Nitrate Therapy** — CARDIZEM may be safely co-administered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

CARDIZEM 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other. Issued 4/1/84

See complete Professional Use Information before prescribing.

0642T5

References: 1. *Physicians' Desk Reference®*, ed 39. Oradell, NJ, Medical Economics Company Inc, 1985. 2. Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed). *Heart Disease. A Textbook of Cardiovascular Medicine*, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39. 3. Schroeder JS: Calcium and beta blockers in ischemic heart disease. When to use which. *Mod Med* 1982; 50(Sept).94-116. 4. Subramanian VB Comparative evaluation of four calcium antagonists and propranolol with placebo in patients with chronic stable angina *Cardiovasc Rev Rep* 1984, 5:91-104. 5. Schroeder JS, Feldman RL, Giles TD, et al. Multiclinic controlled trial of diltiazem for Prinzmetal's angina. *Am J Med* 1982; 72:227-231. 6. Weiner DA, McCabe CH, Cutler SS, et al. The efficacy and safety of high-dose verapamil and diltiazem in the long-term treatment of stable exertional angina. *Clin Cardiol* 1985; 7.648-653. 7. Shapiro W Calcium channel blockers. Actions on the heart and uses in ischemic heart disease. *Consultant* 1984; 24(Dec):150-159

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May 28 — MSMS Hospital Medical Staff Section Leadership Conference, Novi Hilton, contact: Thomas White, MSMS headquarters (517)337-1351.

June 10-11 — Flexner and the 1990s: Medical Education in the 20th Century, co-sponsored by AMA and University of Illinois, University Medical Campus in Chicago, contact: Michelle Zaba, AMA (312) 645-4418.

June 12-16 — AMA-Hospital Medical Staff Section Seventh Assembly Meeting, Hyatt Regency Hotel, Chicago, contact: Dewitt C. Miner, Department of Hospital Medical Staff Services, AMA, 535 North Dearborn Street, Chicago 60610 (312)645-5000.

June 13-19 — AMA Annual Meeting, Chicago Marriott Hotel, contact: Michelle Zaba, AMA (312)645-4418.

June 15-18 — AMA Auxiliary Annual Session, Drake Hotel, Chicago, contact: Viola M. Heins, MSMS headquarters (517)337-1351.

June 27 — Practice Management Seminar: Computers in the Medical Practice, Hilton Shanty Creek, Bellaire, contact: Donna Farougi, MSMS headquarters (517)337-1351.

July 17-20 — MSMS Midsummer Board meeting, St. Clair Inn, St. Clair, contact: William Madigan (517)337-1351.

August 22 — Practice Management Seminar: Computers in the Medical Practice, Boyne Mountain, Boyne Falls, contact: Donna Farougi, MSMS headquarters (517)337-1351.

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It is, essentially, a hand-crafted car.

Now, why do some of the true industrial geniuses of America, Europe and Japan wend their way to our plant, tucked away in a far corner of the English countryside?

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Shockwaves at Indy.

That Lotus is made of the stuff of legends first became evident at the Indianapolis 500 in 1963 when a knee-high mini-rocket came blazing out of nowhere to change the face of racing forever.

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Lotus look-alikes began appearing on Grand Prix courses as fast as they could b
hammered out.

Being mere copies, they performed lik

And Lotus went on to burn itself into t
record books at a pace unparalleled in the history of racing.

But enough perspective. Now, what is Lotus today?

It is one of the very few race cars ever to
the complete transition to pure sports car

In a World of Mass Produced Sports Cars, Stubborn Individualism.

While we at Lotus wholeheartedly embrace today's technology, we employ it to augment the hand, not replace it.

Our computer-guided milling machin
assure us of critically precise engine tolerances. Computer-controlled optical scan

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Still, the engine is unhurriedly assembled y hand, with all parts (right down to the lve springs) so carefully matched and balnced that it takes two full weeks to complete single engine.

Because the same care is taken in building e entire car, six weeks are required from round zero to its first test run.

The chassis is hand-assembled and hand-elded. The entire unit is then galvanized to ck out corrosion.

The body is of a special carbon-fiberglass mposite developed by Lotus. It *can't* rust.

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The Lotus body is given nine coats of paint. ach coat is rubbed down by hand. The final oat is a clear coat, hand polished to give otus the most envied finish in the business.

Lotus tires are not your usual stock item. ur engineers worked long hours with Goodear in developing a tire specifically for the urbo Esprit. One that works in total harony with the car's weight, power and spension system.

And now the big one. Can such a precision strument take a beating?

Consider the unfortunate film director ho, not so long ago, sent a Lotus ying off a cliff in expectation of ooting a spectacular fall, folwed by a crashing breakup.

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So What Could We Improve?

This 16-valve, 4-cylinder mid-engine dynamo will take you from 0 to 150 faster than a prudent man would care to do it.

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Not for speed. For quickness. Which is what real driving is all about.

A computerized fuel metering system is now also part of the power plant. It virtually *anticipates* split-second power needs. And improves gas mileage, giving the car a touring range of over 500 miles.

And to give you more of the open road while you're out there, a totally integrated, removable roof panel is now standard on every Turbo Esprit.

We also made refinements in the turbocharger, suspension, brakes and tires to keep the car in tune with its new power.

The Esprit is now as close to perfect pitch –power, precision, predictability working in unison–as a car is likely to get.

"It puts me at one with the road as no car ever has," is how one enthusiast summed it up.

He also commented on feeling secure in the car because it is very forgiving and "...always has something in reserve."

But that's another whole story....

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Lotus

Representative Richard Young reviews Medicaid fraud and abuse bill

State Representative Richard A. Young, (D-Dearborn Heights), met with the MSMS Medicaid Liaison Committee March 12 in East Lansing. The group discussed House Bill 5382, sponsored by Rep. Young, and designed to combat Medicaid fraud and abuse. Committee members expressed concern about specific provisions of the bill. Changes were made to accommodate those concerns.

Rep. Young, vice chairman of the House Appropriations Committee, and Allen F. Turcke, MD, co-chairman of the MSMS Medicaid Liaison Committee, listen intently to the discussion. Cecil R. Jonas, MD, not pictured, is co-chairman as well.

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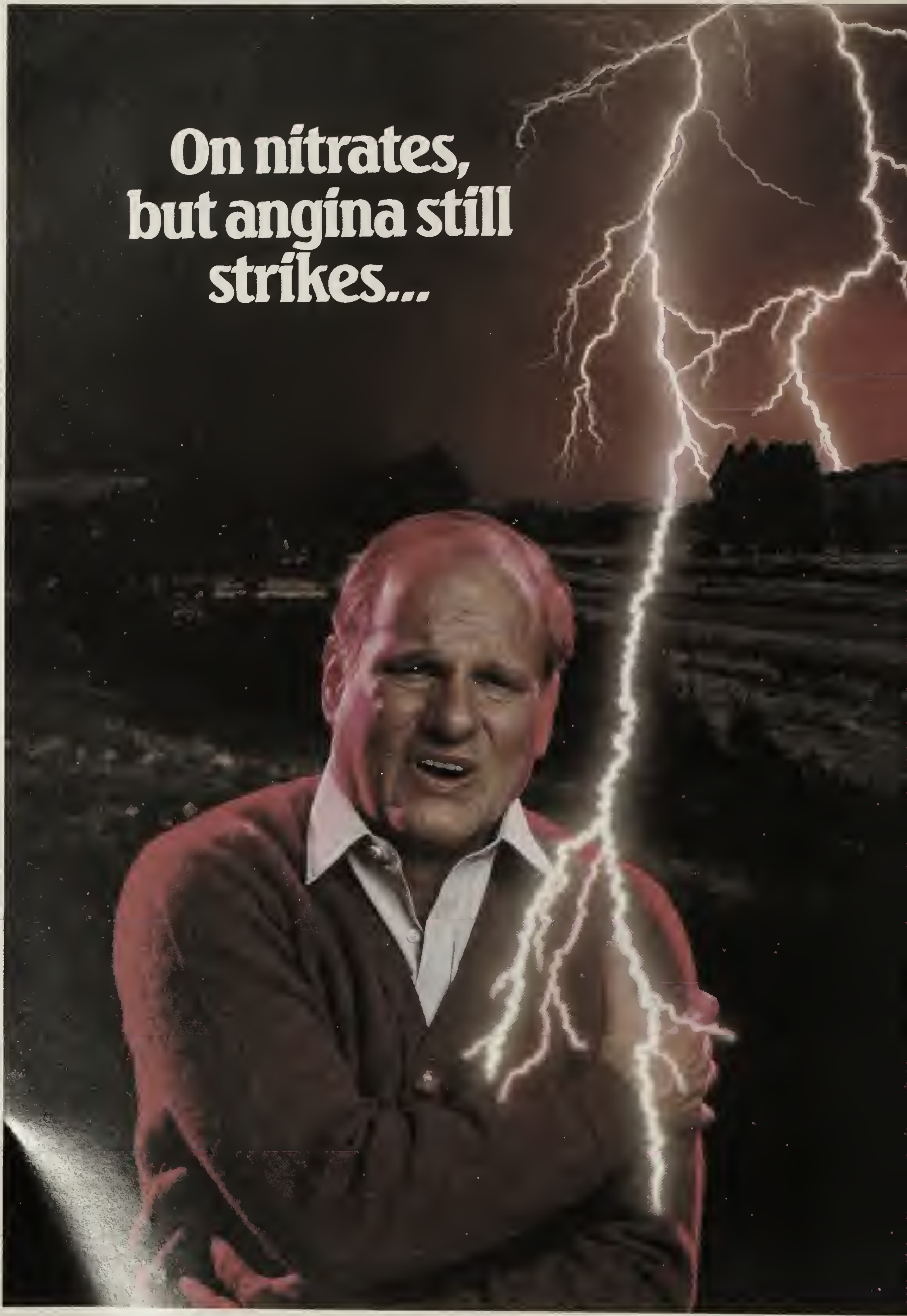
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First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.

ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page

ISOPTIN®
(verapamil HCl/Knoll)
80 mg and 120 mg scored, film-coated tablets

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.*) Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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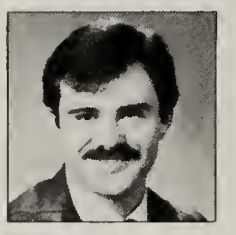

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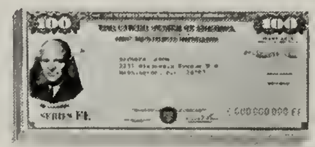

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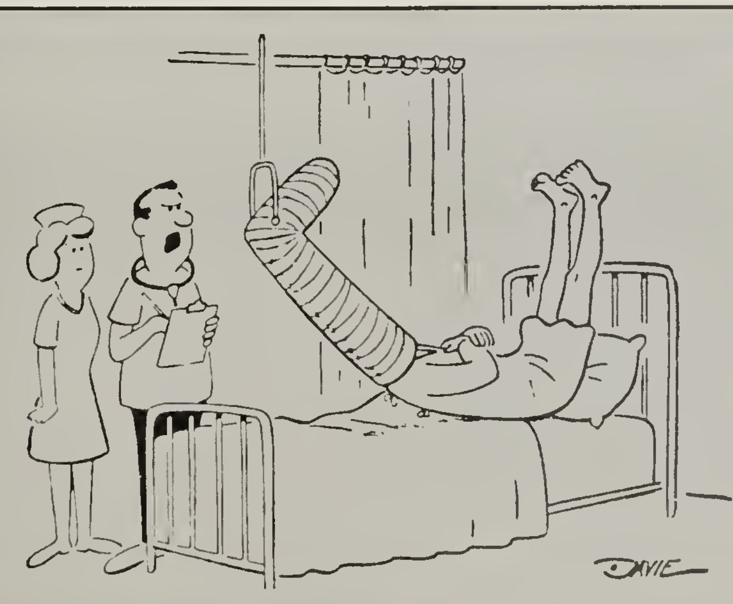
Presidential meeting

Kent County Medical Society members had an opportunity recently to have dinner with three presidents, pictured above. They are, from left to right, Albert R. Dugan, MD, president of the KCMS; Harrison L. Rogers, Jr., MD, AMA president; and Richard J. McMurray, MD, then president of MSMS and now immediate past president.

Doctor Rogers, the featured speaker, drew 200 people to the March 11 meeting at the Grand Rapids Hilton. He is a general surgeon from Atlanta, and became AMA president in June, 1985. He had been vice speaker, then speaker, member of the Board of Trustees and chairman of several AMA committees.



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Allen Silbergleit, MD, Pontiac, recently was elected president of the Southeastern Michigan Surgical Society. Other new officers of the society are **Janusz A. Subczynski, MD,** Harper Woods, president elect; **Alexa Canady, MD,** Detroit, secretary; and **Norman A. Bolz, MD,** Wayne County treasurer. New council members are **David B. Hawtof, MD,** Southfield and **Hubert C. Huebl, MD,** Dearborn. . . . Four Bon Secours Hospital physicians were honored recently for their 30 years of service to the hospital and community. They are **Albert J. Ceravolo, MD,** Detroit; **Charles J. Holt, MD,** Grosse Pointe; **Dwight J. Dutcher, MD,** and **Salvatore Longo, MD,** both of Wayne County. . . .**Donald G. Blain, MD,** Mt. Clemens, 1985 president of the Michigan Branch of the American Urological Association, was recently elected to membership in the International Society of Urology. . . .**Mark W. Hinshaw, MD,** of Grand Rapids was recently installed as president of the Michigan Council of Child Psychiatry. . .**Robert A. Teitge, MD,** Warren, recently was appointed to a position on the *Detroit News* Fitness Panel. As part of the weekly Fitness section featured in the newspaper, the panel will answer readers" questions related to health, diet and exercise. . . .**Fleming Barbour, MD,** Flint ophthalmologist, was recently honored by the American Lung Association as the 1985 Health Advocate of the Year. . . .**James C. Lathrop, MD,** Saginaw, was selected to present a scientific paper at the Annual Frederick A. Coller Resident Surgeons Day Competition. . . .**Herbert I. Krickstein, MD,** Detroit, was inducted as the president of the American Society of Clinical Pathologists. . . .**Henry J. Spiro, MD,** Southfield, has been named vice president of the Society of Geriatric Ophthalmology, a national organization dedicated to education, research and prevention of vision problems and blindness in America's elderly. . . .**Jerrien Van Dellen, MD,** Ellsworth, was recently honored by the Ellsworth/Atwood Chamber of Commerce for 50 years of service in the medical field. . . .**John W. Rebuck, MD,** Birmingham, **D. Emerick Szilagyi, MD,** Bloomfield Hills and **Brock Brush, MD,** Dearborn, were recently honored by Henry Ford Hospital with Distinguished Career Awards for their contributions to patient care, medical education and scientific advancement. . . .**Larry Robson, MD,** Grand Rapids vascular surgeon, was recently elected an alumni representative to the Albion College Board of Trustees. . . . **Alexander Gotz, MD,** Ann Arbor, was recently presented the Michigan Laureate Award of the American College of Physicians for commitment to excellence in medical care and service to the community. . . . **Amir H. Mehregan, MD,** Monroe, was recently elected to represent the Monroe County Medical Society on the Mercy Memorial Hospital Board of Trustees. . . .**Bernard J. Woodley, MD,** Trenton, was recently recognized for 25 years of continued membership in the American Academy of Family Physicians. Doctor Woodley is the current president of the Academy. . . .**Herbert Goldstein, MD,** Birmingham, was recently selected as third vice president of the American College of Utilization Review Physicians at its annual seminar in Washington, DC. . . .**Robert D. Sparks, MD,** Battle Creek, president of the Kellogg Foundation, has been appointed to President Reagan's Board of Advisors on Private Sector Initiatives (PSI). The purpose of the PSI is to identify ways the private sector can meet important societal needs.☐

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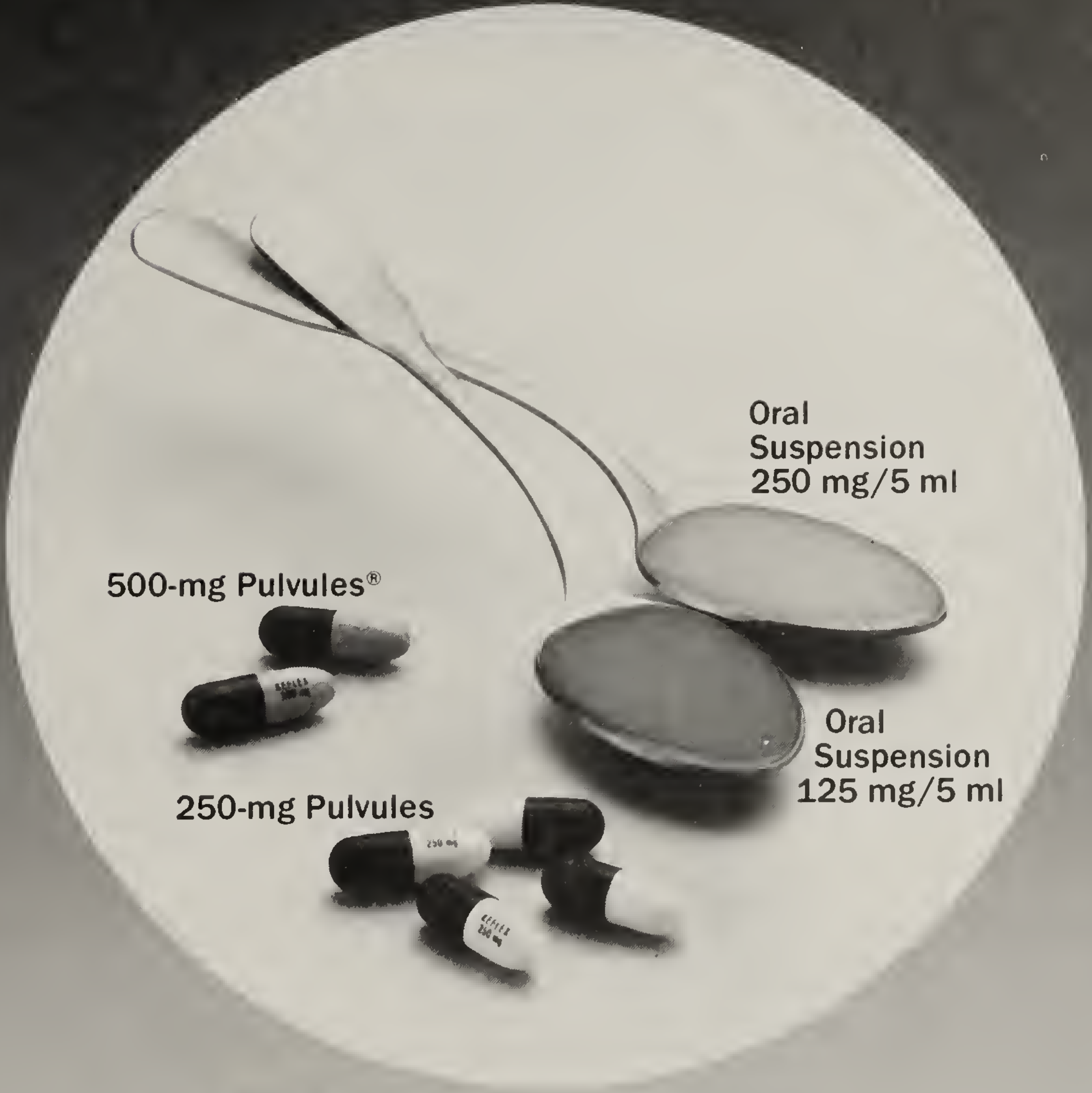
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3990 John R
Detroit 48201

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Livonia 48152

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Pontiac 48053

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2261 Douglas Drive
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Otsego 49078

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4259 Antique Lane
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Grosse Pte. Park 48230

MSMS *Roster* corrections

The following physicians should have been identified as AMA members in the January, 1986 *Roster* of members of the Michigan State Medical Society. An asterisk (*) should have appeared next to each of their names. The editor regrets any inconvenience the omission may have caused.

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DEATHS

Paul H. Bassow, MD
Ann Arbor
Doctor Bassow, 85, died February 7. He was a 1928 graduate of the University of Michigan Medical School. He was former chief of staff at St. Joseph Mercy Hospital and former president of the Washtenaw County Medical Society.

Arthur L. Benedict, MD
Muskegon
Doctor Benedict, 75, died February 14. He was a 1928 graduate of University of Michigan Medical School. Doctor Benedict was a former president of the Muskegon County Medical Society and was affiliated with Hackley and Mercy hospitals.

Elias L. Dickson, MD
Detroit
Doctor Dickson, 71, died February 20. He graduated from Meharry Medical College in Nashville, Tennessee in 1939. Doctor Dickson specialized in obstetrics/gynecology for 42 years in Detroit and was affiliated with Burton Mercy and Crittenton General hospitals.

Michael W. Freemen, MD
Detroit
Doctor Freeman, 86, died Feburary 2. He graduated from Wayne State University School of Medicine in 1943. He was affiliated with Detroit Memorial Receiving Hospital and specialized in internal medicine.

Julian M. Guidot, MD
West Bloomfield
Doctor Guidot, 58, died March 1. He was a 1952 graduate of Wayne State University School of Medicine. He had practiced internal medicine in Detroit for 30 years.

A. Ray Hufford, MD
Grand Rapids
Doctor Hufford, 88, died February 4. He graduated from Loyola University Medical School in 1922. He practiced in Grand Rapids for 55 years specializing in diseases of the gastrointestinal tract. Doctor Hufford was a life member of the Gastroenterology Association.

Glenn E. Millard, MD
Grosse Pointe Park
Doctor Millard, 71, died March 16. He was a 1941 graduate of University of Kansas Medical School. Doctor Millard specialized in surgery and was affiliated with Grace Hospital and Straith Memorial Hospital.

O. Paul Rosbolt, MD
Livonia
Doctor Rosbolt, 53, died March 10. He graduated from University of Michigan Medical School in 1957 and interned in obstetrics/gynecology at Indiana University from 1958-1961. Doctor Rosbolt was affiliated with Harper-Grace Hospital.

Norbert W. Scholle, MD
Muskegon
Doctor Scholle, 77, died February 12. He was a 1934 graduate of Harvard Medical School. Doctor Scholle specialized in surgery and practiced medicine for more than 50 years. He was a former president of the Muskegon County Medical Society.

Bernard H. Smookler, MD
Grand Ledge
Doctor Smookler, 57, died February 27. He graduated from the University of Illinois Medical School in 1953. Doctor Smookler was former chief of staff of Sparrow Hospital and past president o the Ingham County Medical Society.

J. Copner Webster, MD
Birmingham
Doctor Webster, 53, died January 23. He graduated from the University of Liverpool in 1957 and specialized in otolaryngology. Doctor Webster was a member of the Fellowship, Royal College of Surgeons.

Theodore M. White, MD
Detroit
Doctor White, 83, died February 23. He was a 1931 graduate of Meharry Medical School in Nashville, Tennessee. Doctor White specialized in surgery and was affiliated with North Detroit General and Trinity hospitals.

Gordon Willoughby, MD
Frankfort
Doctor Willoughby, 56, died March 13. He graduated from the University of Michigan Medical School in 1959. Doctor Willoughby was former president of the Michigan Academy of Family Physicians and Tri-County Medical Society. He was also former chief of staff at Paul Oliver Memorial Hospital.

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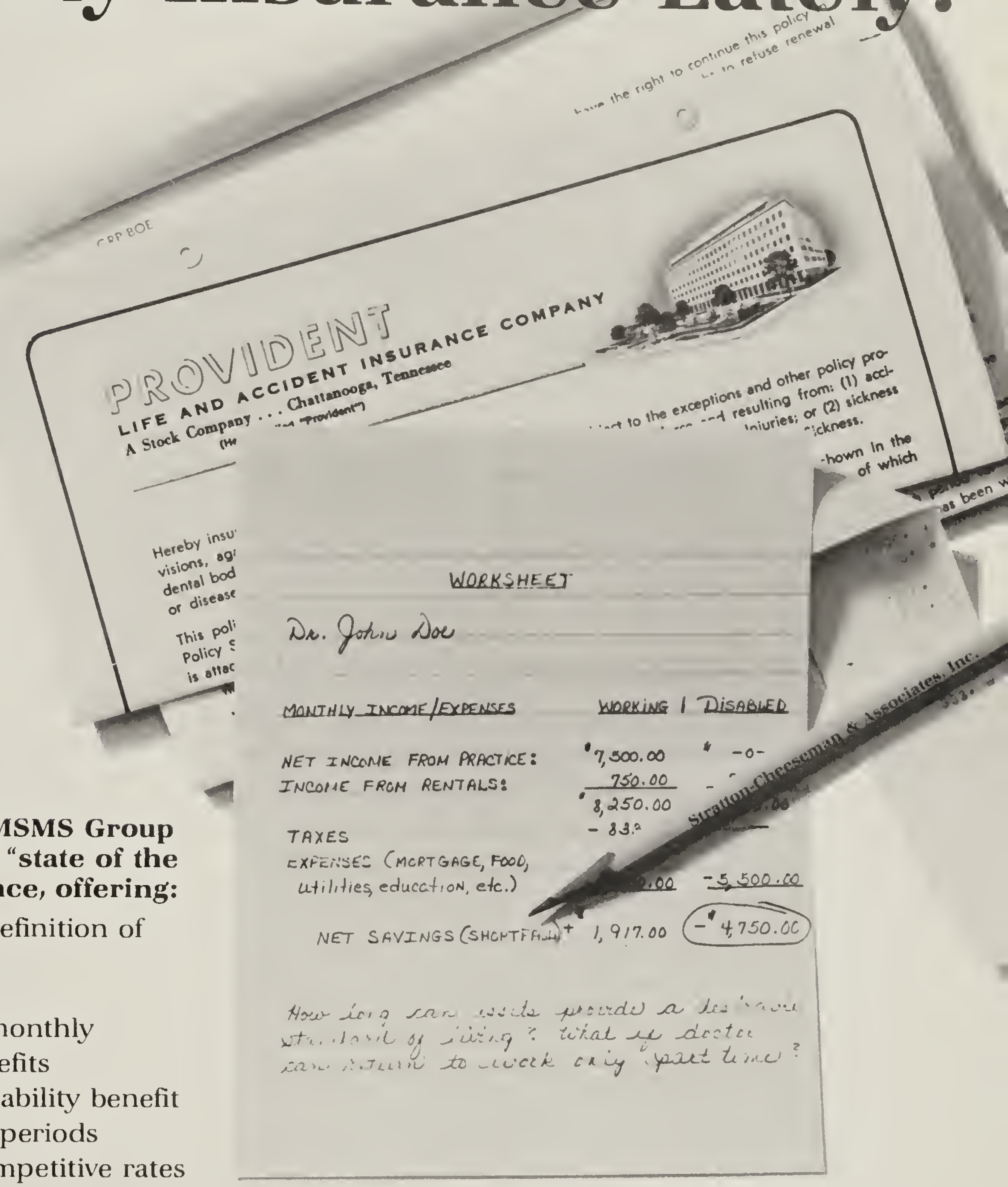

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

Date: May 28-June 1, Tutorial on Direct Action Thrust Manipulative Technique. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: June 4, Michigan Cleft Palate Symposium. Location: Towsley Center, Ann Arbor. **Sponsor:** Center for Human Services, Western Michigan University, Michigan Cleft Palate Clinic Coordinators, Crippled Children's Program, Department of Public Health, Mott Children's Hospital, University of Michigan Medical Center, Blodgett Memorial Medical Center, Southwestern Michigan Area Health Education Center. **Contact:** Janet Wilson, Centre for Human Services, Western Michigan University, Kalamazoo (616)383-4941. **Approved for:** 4.5 hours of Category I Credit.

Date: June 5-7, Advanced Trauma Life Support Provider Course. Location: Heritage Hospital, Taylor. **Sponsor:** Heritage Hospital. **Contact:** Patricia Trent, Heritage Hospital (313)295-5000. **Approved for:** 19 hours of Category I Credit.

Date: June 5-6, 12th Annual Kalamazoo Symposium for Michigan Neonatologists and Neonatal Fellows. Location: Gilmore Health Education Center, Kalamazoo. **Sponsor:** Neonatology Service, Bronson Methodist Hospital and Southwestern Michigan Area Health Education Center. **Contact:** John V. Hartline, MD, Bronson Methodist Hospital, 252 E. Lovell Street, Kalamazoo 49007 (313)383-6469. **Approved for:** 6 hours of Category I Credit.

Date: June 5-6, Surgery Education. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 14 hours of Category I Credit.

Date: June 9-13, Principles of Manual Medicine. Location: Kellogg Center, MSU. **Sponsor:** MSU Colege of Osteopathic Medicine, College of Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: June 11-13, Clinical Laboratory Computers. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School 48109-0010 (313)763-1400. **Approved for:** 11.5 hours of Category I Credit.

Date: June 12-14, 37th Annual Keyport-Gaylord Trauma Symposium. Location: Hidden Valley Club, Gaylord. **Sponsor:** Wayne State University School of Medicine. **Contact:** Robert F. Wilson, MD, Wayne State University Department of Surgery, 6-C UHC, 4201 St. Antoine, Detroit (313)577-5009. **Approved for:** 15 hours of Category I Credit.

Date: June 12-14, Neonatal/Infant/Child Life Support. Location: Gilmore Health Education Center, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association and Southwestern Michigan Area Health Education Center. **Contact:** William H. Scott, MD, Southwestern Michigan Perinatal Association, 252 E. Lovell Street, Kalamazoo 49007 (313)383-6469. **Approved for:** 19 hours of Category I Credit.

Date: June 20, Flexible Sigmoidoscopy. Location: Gilmore Health Education Center, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Chris Pearson, SMAHEC, 4th Floor, Stryker Center, 1521 Gull Road, Kalamazoo 49001. **Approved for:** 5.5 hours of Category I Credit.

Date: June 22-27, 22nd Annual Northern Michigan Summer Conference: An Update on Common Clinical Concerns. Location: Hilton Shanty Creek, Bellaire. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 19 hours of Category I Credit.

Date: July 24-25, Clinical Nutrition Update. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 11.5 hours of Category I Credit.

Date: July 24-25, Coller Penberthy Thirlby Medical Conference. Location: Grand Traverse Resort, Grand Traverse Village. **Sponsor:** Munson Medical Center. **Contact:** Norma Powers, Coordinator of Medical Education, Munson Medical Center, 6th and Madison, Traverse City 49684 (616)922-9544. **Approved for:** 9 hours Category I Credit.

Date: July 25-28, Advances in the Management of Infectious Diseases. Location: Grand Hotel, Mackinac Island. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: August 1-3, Tutorial on Level II Myofascial Release Technique. Location: Homestead Resort, Glen Arbor. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing (517)353-9714. **Approved for:** 24 Hours of Category I Credit.

Date: August 14-17, 18th Annual Summer Conference. Location: Grand Hotel, Mackinac Island. **Sponsor:** Michigan Ophthalomological Society. **Contact:** Jane Panin, 412 Eastland Center Professional Building, Harper Woods 48225-1084 (313)839-3011. **Approved for:** 8 hours of Category I Credit.

Date: August 17-20, Internal Medicine Update. Location: Grand Hotel, Mackinac Island. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School 48109-0010 (313)763-1400. **Approved for:** 11.1 hours of Category I Credit.

Date: September 3, Update '86—Rehabilitation of Traumatic Brain Injury. Location: Kalamazoo, Michigan. **Sponsor:** West Michigan Physiatry, PC and Southwestern Michigan Area Health Education Center. **Cost:** $50. **Contact:** Doctor Bryan Visser, West Michigan Physiatry, PC, 252

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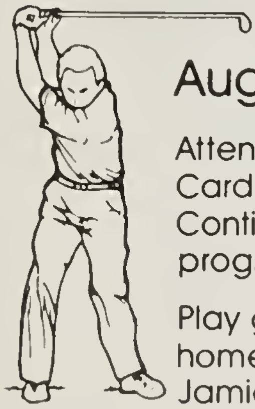

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. Lovell Street, Suite 363E, Kalamazoo 49007. **Approved for:** 5.75 hours of Category I Credit.

Date: September 6, Basic Cardiac Life Support Course for Physicians. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 6 hours of Category I Credit.

Date: September 6-7, Chief Surgical Residents. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: September 7-8, Advanced Cardiac Life Support Provider Course. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School (313)763-1400. **Approved for:** 16 hours of Category I Credit.

Date: September 11-13, Grand Rapids 17th Annual International Symposium on Implant Surgery for the Hand-Upper Extremity. Location: Blodgett Memorial Center and Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** Michigan State University College of Human Medicine and International Federation of Societies for Surgery of the Hand. **Contact:** Alfred B. Swanson, MD, Blodgett Professional Building, Suite 290, 1900 Wealthy Street, SE, Grand Rapids 49506. **Approved for:** 18 hours of Category I Credit.

Date: September 12-13, Perinatal and Enteral Nutrition 1986: Clinical Update. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: September 12-13, Hypertension 1946-1986: The First Ann Arbor International Reunion. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: September 13-17, Tutorial on Level I Muscle Energy Technique. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: September 25-27, November 13-15, Neonatal/Infant/Child Life Support. Location: Gilmore Health Education Center, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association and Southwestern Michigan Area Health Education Center. **Contact:** William H. Scott, MD, Southwestern Michigan Perinatal Association, 252 E. Lovell Street, Kalamazoo 49007 (313)383-6469. **Approved for:** 19 hours of Category I Credit.

Date: September 25-27, Diagnostic Ultrasound. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 15 hours of Category I Credit.

Date: September 26-28, American Academy of Pediatrics, Michigan Chapter 37th Annual Scientific Meeting. Location: Hilton Shanty Creek Summit Conference Center, Bellaire. **Sponsor:** Michigan Chapter, American Academy of Pediatrics. **Contact:** Mr. P. Miles Tiernan, 32245 Hearthstone, Farmington Hills 48018. **Approved for:** 7 hours of Category I Credit.

Date: September 26-28, Tutorial on Level I Myofascial Release Technique. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East

Continued on page 278

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Date: September 29-October 1, Hemodynamic Monitoring and Management Seminar. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 14 hours of Category I Credit.

Date: October 1-3, Mechanical Ventilatory Support and Management. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 15 hours of Category I Credit.

Date: October 2-3, Diabetes Care. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 16 hours of Category I Credit.

Date: October 4-5, National Conference for Chief Medical Residents. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 10 hours of Category I Credit.

Date: October 9-10, Ear, Nose and Throat Practicum. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 16.5 hours of Category I Credit.

Date: October 9-10, Ins and Outs of Critical Care: Fluids, Nutrition and Renal Management. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010, (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: October 11-15, Tutorial on Level II Manual Medicine Techniques (Above Diaphragm). Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: October 16-17, Perinatology and Neonatology. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: October 16-18, Common Surgical Problems in Childhood. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 18 hours of Category I Credit.

Date: October 19-23, Tutorial on Level II Craniosacral Techniques. Location: Kellogg Center, MSU. **Sponsors:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: October 20-21, Care of the Elderly. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-0010. **Approved for:** 12 hours of Category I Credit.

Date: October 24-25, Advances in Multidisciplinary Approaches in the Treatment of Cancer of the Breast, Head and Neck, and Ovaries. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 10.5 hours of Category I Credit.

Date: October 24, Basic Cardiac Life Support Course for Physicians. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 6 hours of Category I Credit.

Date: October 25, Advanced Cardiac Life Support Course Recertification. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 8 hours of Category I Credit.

Date: October 27-29, Impairment Evaluation and Disability Considerations: Medical and Legal Perspectives. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 17 hours of Category I Credit.

Date: October 30-November 2, Chest Radiology: Pioneers and New Frontiers. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 14 hours of Category I Credit.

Date: November 7, Basic Cardiac Life Support Course for Physicians. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 6 hours of Category I Credit.

Date: November 7-9, Tutorial on Manual Medicine Techniques Applied to the Extremities. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 24 hours of Category I Credit.

Date: November 8-9, Advanced Cardiac Life Support Provider Course. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 16 hours of Category I Credit.

Date: November 12-14, Real-Time Ultrasound in Obstetrics and Gynecology. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 21 hours of Category I Credit.

Date: November 13-15, Neonatal/Infant/Child Life Support. Location: Gilmore Health Education Center, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association and Southwestern Michigan Area Health Education Center. **Contact:** William H. Scott, MD, Southwestern Michigan Perinatal Association, 252 E. Lovell Street, Kalamazoo 49007 (313)383-6469. **Approved for:** 19 hours of Category I Credit.

Date: November 17-18, Laser Medicine and Surgery: The Aerodigestive Tract. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 17 hours of Category I Credit.

Date: November 19-21, Laser Medicine and Surgery: Specialty Applications. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 22.5 hours of Category I Credit.

Date: December 15-19, Principles of Manual Medicine. Location: Kellogg Ceter, MSU. **Sponsor:** MSU College of Osteopathic Medicine, College of Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Mutual Memo

2

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Second in a series

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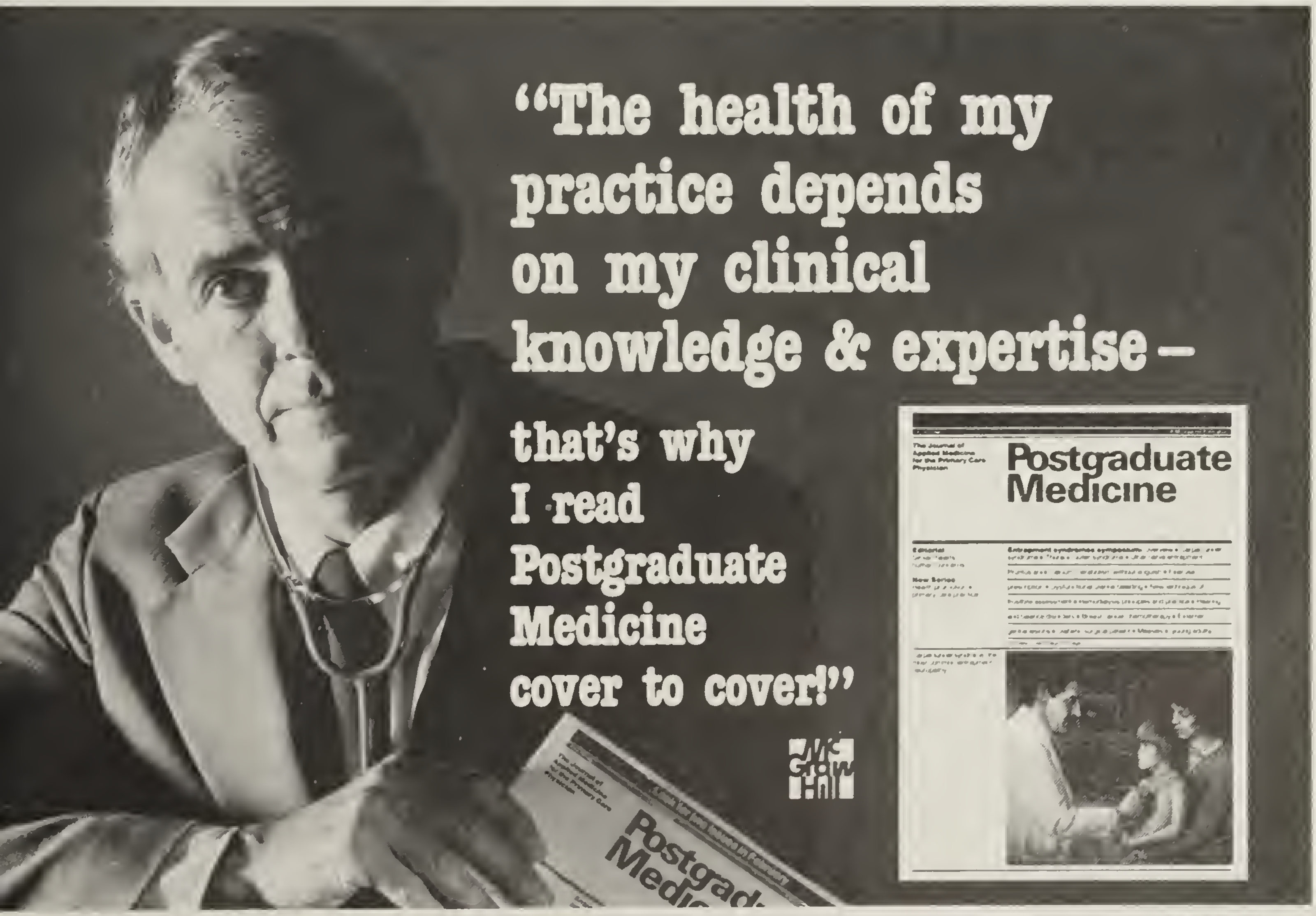

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creased, payors, patients and insurance companies are demanding changes such as preadmission testing, outpatient surgery, outpatient testing, shorter hospital stays, reduced laboratory use and so on.

In 1986 the medical profession is confronted with many urgent questions, unsolvable problems and confusing trends. In this time of transition our vast, complex social contract, inaugurated in 1935 and capped 30 years later by Medicare and Medicaid, has been under intense review. The DRGs, which are still applied in most areas only to hospitalized Medicare patients, have spotlighted many problems. They have raised conflicts between doctor and patient as well as between doctor and hospital administrator. This conflict tests the physician's will and authority to protect the patient's vital interests. An office based DRG is probably not ikely, but a new relative value system is in the process of being developed by the AMA, specialty groups and Harvard University.

More challenges

Physicians will be strenuously challenged to take a more active interest in the special problems of their aging patients, utilizing and supervising more home care and less nursing home care.

Medicine has taken a leadership role in moving to eliminate cigarettes, to outlaw boxing and to promote preventive health services. The AMA, acting for the profession, has taken clear and logical positions on matters as natural rights of parents and the professional functions of physicians in the treatment of newborns.

Many problems continue to exist, not the least of which is professional liability. Others are definition of "physician" under Medicare, mandated assignment, the fee freeze and various aspects of the PRO Program.

During my years of involvement with Michigan State Medical Society we have taken stands on many issues and have gotten much legislation passed, including the Revised Medical Practice Act, Safety Plate Glass Bill, lead paint, Public Health Statutes Revision, and so on. Attempts to broaden the scope of chiropractic practice as well as extension of the practice of other paramedical groups continues. When I was chairman of the committee on state legislation we had an MSU student member for three years. At his last meeting he got up and said, "I came on this committee only as a cynic to see what self-serving issues you fat cat physicians were pushing. After three years I can honestly say that not one vote on any issue was not in the best interest of the patients."

Fifty years ago Doctor Perry lead this society which had far different problems than we have today. MSMS, and each of us personally, will have to work to solve our present problems. Many of our battles will be in our state and federal legislatures. At our Rally at the Capitol I mentioned that it certainly was gratifying to have such support. In a recent *Michigan Medicine* guest President's Page I outlined ways for our membership to stay involved now that their feet are wet.

During the next year I pledge to you that I will continue to work for you and our patients, and in my visitations I will try to motivate our members to get and *stay* involved. Together we can make some headway in the inevitable changes that will take place in our practices, always doing what is in the best interests of our patients.

Thank you for your confidence in electing me as your president. I look forward to the challenge and will do the best possible job I am able.☐

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By Thomas R. Berglund, MD

Changing practices, changing methods

Exactly 50 years ago, in 1936, the president of Michigan State Medical Society was Henry E. Perry, MD, of Newberry. He was a general practitioner and our family physician. He delivered all of the Berglund children, and I can tell you from the things that my mother told me that Doctor Perry was a remarkable physician living in a small upper peninsula town. He used much common sense, accepted new ideas, was extremely honest, dedicated and devoted to his patients and his profession, and was willing to accept changes as they came.

In the 50 years since Doctor Perry was president, many significant changes have taken place. In 1937 sulfa drugs became available, followed in the early 40s by penicillin and other antibiotics.

My father died in 1942 of subacute bacterial endocarditis which we now treat successfully. In 1940 he had sent our family away from Newberry because of a polio epidemic. When I returned, many children in our little town were dead and many more were crippled. In 1955, while I was a freshman in medical school, the Salk field trials were conducted in Ann Arbor, then in the early 60s we saw the introduction of the Sabin vaccine. We don't see polio anymore.

Effective antituberculous therapy has closed the tuberculosis sanitoriums. Successful treatment with phenothiazines and other major tranquilizers have emptied our state hospitals and returned many mental patients to useful activity in our society. In the mid-1950s the first mitral commissurotomy was done and now look at what we're doing with coronary bypass surgery, heart transplants, pacemakers and balloon dilatations.

Twenty-five years ago, when I started practice, we were using ether. The development of new anesthetic agents and techniques has paved the way for modern surgery. The advancements in diagnostic and therapeutic radiation have been immense. How *did* we practice before the CT scan?

Changing practices

All of us have been willing to accept these changes in our practice that have eliminated smallpox, practically eliminated polio, measles, German measles and erythroblastosis, and improved the lives of patients with heart disease, cancer, diabetes and hypertension, just to name a few.

We have, however, been reluctant to change our practice methods. As costs have in-

Continued on page 283

With this column Doctor Berglund, new MSMS president, begins a year of *Michigan Medicine* correspondence.

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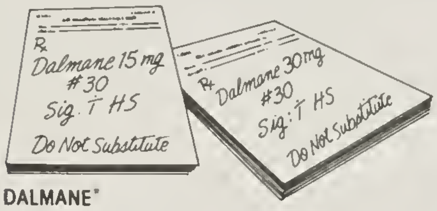

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MICHIGAN MEDICINE

June 1986 AWARD-WINNING JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 85, No. 6

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Societal issues and the gift of life

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June 1986, Vol. 85, No. 6

MICHIGAN MEDICINE

About the cover: The gift of an organ — the gift of life — may soon come in a new package in Michigan.
Photo by Kim Kauffman

In next month's issue of *Michigan Medicine:* Physician Service Group, Inc., an MSMS subsidiary, offers a variety of services to individual physicians and to physician groups. Those offerings will be detailed in the July issue.

Special report

288 Organ transplantation in the 1980s has become more than just a technological matter. Reimbursement, procurement, donation and recipient selection issues are as complicated and delicate as the surgery. This Special Report poses related questions, gives some existing answers, and lists resources for organ donations and procurement. The process for determining Michigan transplantation sites is outlined in one article, and legislative efforts to encourage organ donations are explained in two more. A Center for Public Policy Research has been established to collect and analyze transplantation data. A description of that center's work is included here: Robert D. Allaben, MD; Rep. Richard Bandstra; Marcia Carlyn, PhD; Sen. Gilbert J. DiNello; Robert S. Hicks and George D. Zuidema, MD.

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18 66

50-year awardee expresses thanks

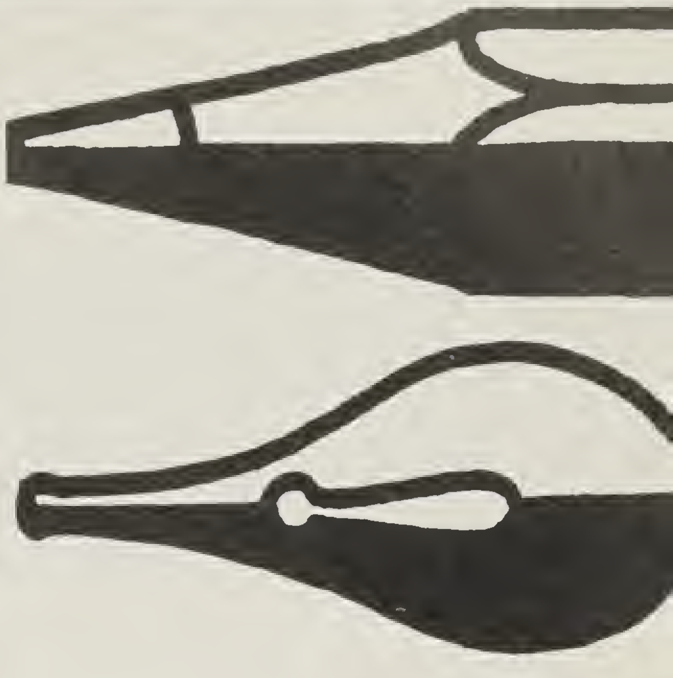
The following letter was received at Michigan State Medical Society headquarters from Doctor William Chase, one of 86 MSMS members honored last month at the House of Delegates meeting for their 50 years of medical practice:

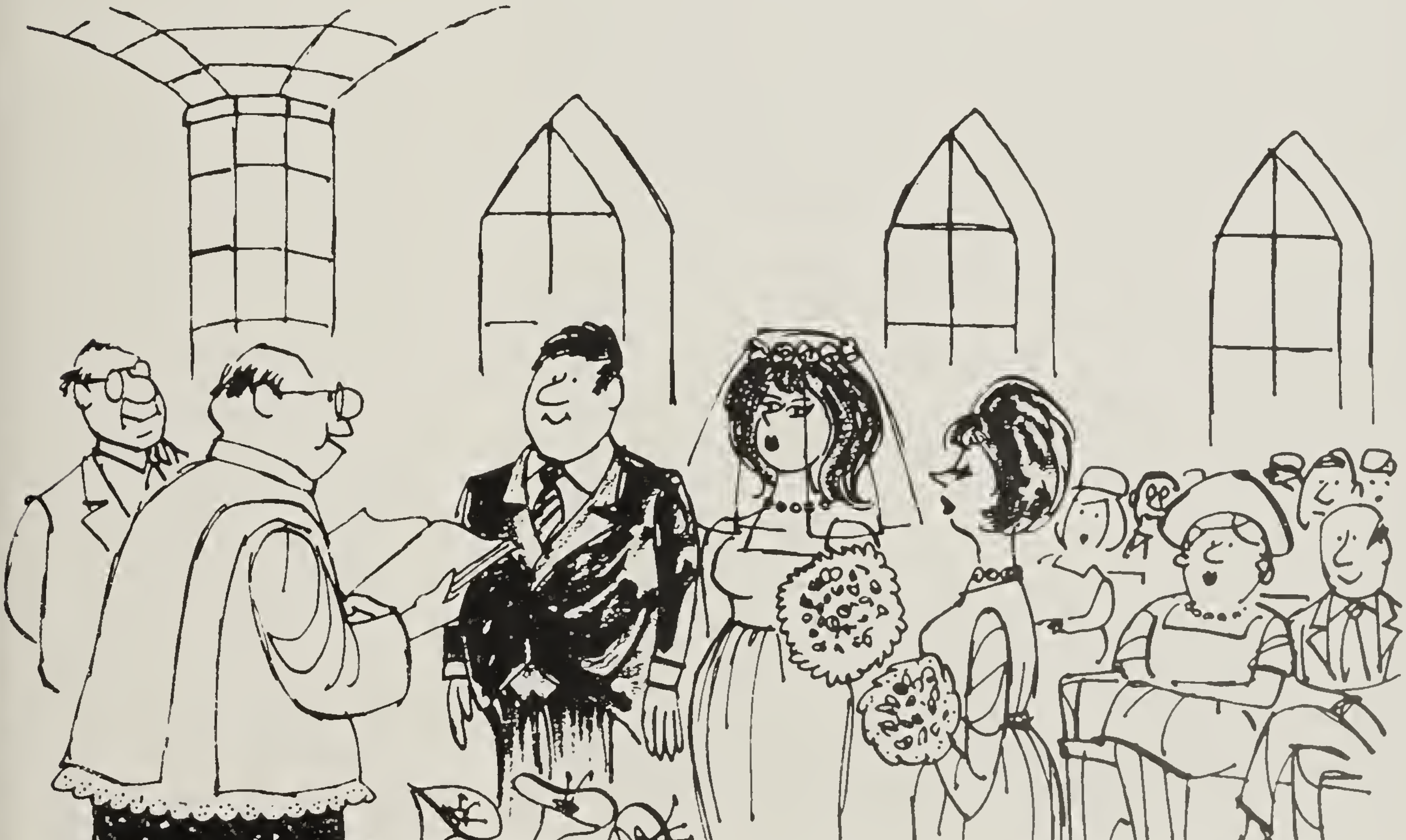
What wouldn't I give to be present on May 3 to be one of the physicians being honored for having graduated in 1936 from medical school!

Thank you kindly for the letter of May 3 (news release). It is most flattering and I can only wish I could measure up to such standards of performance. I did my best, however, and want to congratulate all the other doctors being honored on this occasion.

God bless you all with many more years of happy service to your flocks.

William D. Chase, MD
Flint





"Do you promise to love, cherish, and protect her in sickness and in health and until Medicare can take over?"

SPECIAL REPORT

By Robert D. Allaben, MD

Organ transplantation questions begin to get answers

Allaben

Advances in organ transplantation in the 1980s have necessitated the reexamination of old views and the introduction of new attitudes relative to reimbursement, organ donation, organ procurement, recipient selection and many ethical issues.

How much do we wish to spend on this technology? How do we increase the supply of organs for transplantation? How can we obtain, preserve and transport organs for transplantation so that all retrieved organs are in fact transplanted? Which recipients should receive these scarce commodities? Should the most desperately ill patients (the poorest operative risks) have first choice of available organs? Although temporarily behind some states, Michigan has attempted to address these questions and problems in an orderly and rational manner.

Improved surgical techniques and immunosuppressive manipulations have expanded the field of transplantation and made what was experimental and limited to very few research institutions common and done by many centers. Just in 1981 there were only 62 heart and 26 liver transplants done. In 1985, 719 heart and 602 liver transplants were carried out.

In late 1984 Jay Endsley and Richard Schmidt from the Governor's Office of Health and Medical Affairs asked the Michigan State Medical Society to look at transplantation and its impact upon the State of Michigan. The Board of Directors appointed an ad hoc committee composed of members from all potential transplant centers and appropriate specialties. Heart, heart/lung, liver, pancreas and bone marrow transplants were addressed. The committee investigated the potential needs, required characteristics of a transplant program, indications and contraindications for each transplant. The report of this committee was reviewed by the Michigan Department of Public Health (MDPH). The health department has formed a new committee of very similar characteristics plus representation from the Michigan Department of Social Services (MDSS) to develop criteria for the certificate of need (CON) process. (As extrarenal transplants are a new service, they fall within the certificate of need process.)

By the end of 1985, with the help of Robert Levine, DDS, of MDSS, Marcia Carlyn, PhD, and Marty Byington of MDPH the criteria were placed in the proper format and submitted to the Statewide Health Coordinating Council for approval. This approval occurred in January, 1986. CON requests were solicited and were due May 1, 1986. Institutions submitting requests initially will be compared with the criteria developed. Institutions passing this screening each will be reviewed on a competitive basis; during Phase I no more than three facilities will be approved to do each type of transplant. Although perhaps this approval process is occurring later than in some other states, it has occurred with significant input from physi-

---

Doctor Allaben, Detroit surgeon, is chairman, MSMS and MDPH Ad Hoc Committees on Organ Transplantation, and is associate professor of surgery at Wayne State University.

cians closely associated with this new and highly technological field.

UN ORM DONOR CARD

Federal initiatives

At the federal level a 25-member Task Force on Organ Transplantation is just completing its final report. Franklin McDonald, MD, Detroit nephrologist, is on this task force. It has been reported that they will recommend that organ transplants be available to all United States residents based solely on objective medical criteria. These transplants could cost the federal government $42 million to $70 million a year. Studies have indicated that an average kidney transplant costs $35,000 the first year; heart $95,000 and liver $130,000.

Although this is expensive one must compare these costs to the expense of caring for such patients without transplantation. It has been well demonstrated that over a three-year period renal transplantation is significantly less costly than dialysis. (It is estimated that care of a patient with terminal liver failure can easily exceed $75,000.)

Continued on next page

QUESTIONS/Continued

One must also consider the benefits of returning a totally disabled patient to productive work when considering the "high" cost of transplantation. Should the country with the most advanced, highest quality medical care withhold such care purely for economic reasons? Our country and our state should assure that no resident is deprived of available medical treatment because of economic reasons.

Donor shortage

Currently the limiting factor in the field of transplantation is donor organ availability. There are annually approximately 20,000 suitable organ donors in the United States. Of these, only about 20 percent actually become organ donors. Multiple organ retrievals from one donor are occurring more commonly and must be done whenever possible.

Bills such as Michigan House Bill 4965 introduced by Representative Richard Bandstra for "required request" are being passed in other states. (See related article on page 293.) Since passage of such a bill in Oregon, the number of retrieved corneas has doubled and there has been a 50 percent increase in other organs obtained for transplantation.

Through the Organ Procurement Agency of Michigan (1-800-482-4881), surgical teams are available to retrieve all solid organs in any hospital in the state. Eye donations may be achieved by calling the Michigan Eye Bank and Transplantation Center (313) 764-3262 . Tissues and bones may be donated through the Michigan Tissue Bank (1-800-468-2929 or 517-483-2929).

Any organ donation, including eye, skin, bone and vascularized organs may be made through the Organ Procurement Agency of Michigan (OPAM) at (1-800-482-4881 or 313-973-1577). OPAM and the other Michigan agencies have a cooperative relationship. One call to OPAM will result in an appropriate referral.

Costs associated with organ donation are reimbursed to the donating hospital.

Each hospital and its associated personnel *must* develop protocols and procedures for organ donation. They must include criteria for death as well as mechanisms for identification of potential donors and for notification of the appropriate procurement agency. However, even if these mechanisms are in place, they are useless unless physicians and nurses think of organ donation in *all* possible situations.

My initial questions are gradually being answered. The federal and state governments and insurance carriers are beginning to address the costs of transplantation. Hopefully, they will likewise assure that no one is deprived of this treatment mode purely on the basis of economic reasons. Required request laws and increasing public education will increase the supply of organs for transplantation. Specific centers for transplantation will be approved by the State of Michigan. Through them and organ procurement agencies the highest possible number of organs will be transplanted with ever-improving results. Patient selection criteria will be continuously reviewed and modified to allow utilization of this treatment mode whenever indicated.

New questions

New questions will also continue to appear. What is the role of mechanical cardiac assist or replacement devices? Can an artifical lung be developed for prolonged use? Can the failing liver be supported or replaced by mechanical means? Can a sophisticated infusion pump carry out the function of a normal or transplanted pancreas? Can exquisitely matched bone marrow transplants avoid graft vs. host disease? Can we overcome the technical, immunological and infectious problems of small bowel transplantation? Will limb transplantation be possible? These and many other questions not yet thought of will need to be answered.

Because the limiting factor in organ transplantation is organ availability we must constantly remember that organ donation may save a life and that buried organs are of no value to anyone.☐

By Marcia Carlyn, PhD, and Robert S. Hicks

On the designation of transplant centers in Michigan

Organ transplantation in many ways epitomizes the rapid change in medical technology which has been occurring recently. As a result of technological advances, and the availability of long-distance organ procurement, there has been a dramatic increase in the number of successful transplants over the last 10 years. In response, many insurance carriers have begun to routinely cover many types of extrarenal organ transplants. To save reimbursement costs, however, there has been increasing agreement among both private and public insurers that coverage should be restricted to transplants performed at certain designated preferred centers across the country.

Governor Blanchard in 1985 recognized the need to address this issue as well as a number of other issues related to transplants, and directed the Department of Public Health to design and develop a Michigan Transplantation Services program. His executive directive specified two goals to be accomplished by October 1, 1985: 1) the development of planning policies for use in reviewing certificate of need (CON) requests for the establishment of transplant centers in Michigan, and 2) the development of criteria to be used by the transplant centers in the selection of candidates for organ transplant operations.

To accomplish these tasks, the Department convened an ad hoc committee in the summer of 1985. It was comprised of physicians and other clinicians, researchers, hospital administrators, health planners, third party payers, and representatives of consumer groups and purchasers of health care. The role of the Extrarenal Organ Transplantation Ad Hoc Committee was to provide input and advice to the Department with regard to specific minimal requirements for transplant centers and common medical criteria. The work of the Department's committee was greatly facilitated by the prior analysis of these issues by the Michigan State Medical Society Ad Hoc Committee on Organ Transplantation, chaired by Robert D. Allaben, MD, Detroit.

Planning policies

The first product which resulted from the Department's meetings with the Extrarenal Organ Transplantation Ad Hoc Committee was a set of proposed planning policies for reviewing CON applications. Subsequent meetings with the Office of Health and Medical Affairs and an assessment of public comment resulted in revised "Planning Policies Pertaining to Extrarenal Organ Transplantation" which were approved by the Statewide Health Coordinating Council (SHCC) on January 16, 1986, for inclusion in the State Medical Facilities Plan.

Because extrarenal organ transplantation is a new technology, it was decided to use a phased approach to introduce the technology within the state in accordance with the previously approved "Procedures for the Adoption of Review Standards for Future Technological Diagnostic or Treatment Equipment or Services." During Phase I, only a limited number of facilities will be designated as transplant centers. Specifically, no more than three facilities in the state will be approved to do heart and heart/lung transplants. Similarly, no more than three facilities will be approved to do liver transplants, no more than three will be approved for pancreas transplants, and no more than three for bone marrow transplants. Facilities may submit applications proposing to do more than one type of organ transplant if they wish.

A statewide comparative review is currently scheduled to be conducted by the Department of Public Health over a 120-day period beginning on approximately July 1, to determine which applications for a CON will be approved. As a part of the review, each application will be assessed on how well the proposed service meets the requirements specified in the planning policies. In addition to specifying minimal service and staffing requirements, the planning policies require each transplant center to serve as a statewide resource, to have the capability of per-

Continued on next page

Doctor Carlyn is chief, Division of Health Facility Planning and Mr. Hicks is chief, Division of Health Facility Construction, Michigan Department of Public Health.

forming at least 15 to 20 transplant procedures by the third year of operation, to play a significant role in the education of the medical community and the general public, to have a formal research program related to organ transplantation which allows for external peer review, to participate in a statewide transplantation data network which requires providing specific medical and cost data on each transplant procedure performed, and to select candidates for organ transplantation in accordance with patient selection criteria specified by the Michigan Department of Public Health.

Patient selection criteria

The second product resulting from the Department's meetings with the ad hoc committee was the "Extrarenal Organ Transplantation Patient Selection Criteria," a document which categorized specific disease states, based on the expected risk-to-benefit ratio of transplantation, as presenting either appropriate or generally not appropriate indications for a transplant procedure. The criteria are based on the assumption that only those patients with a clearly progressive and life-threatening disease will be candidates for transplantation. Cases where a transplant operation is expected to save a patient's life are given a higher priority than cases where an implanted organ may bring about a significant improvement of indeterminate duration in a chronically ill or severely debilitated patient. It is recognized that decisions regarding the presence of implications for certain medical conditions are best made on a case-by-case basis and that it is not possible or appropriate to set forth inflexible guidelines. Nevertheless, the use of a common set of patient selection criteria is regarded by the Department as being critical to the establishment of an equitable system, where the decision-making process assures all citizens of Michigan fair access to this new medical technology.

Statewide comparative review

After the planning policies were approved by the SHCC in January, public notice of a statewide comparative CON review for extrarenal organ transplantation services was published by MDPH in the usual manner. May 1 was specified in the public notice as the submittal date for the review. As of this date, the Department of Public Health had received CON applications from four facilities seeking to be extrarenal transplant centers.

The comparative review will be conducted by the Department's Division of Health Facility Construction. In accordance with Part 221 of Act 368 (P.A. of 1978) and current administrative rules, each application will be scored and ranked according to how well it meets the requirements specified in the "Planning Policies Pertaining to Extrarenal Organ Transplantation" as well as the criteria specified in Section 22131 of the Public Health Code. No preference will be given to facilities which may be currently performing extrarenal organ transplants. Following the decision in late November, 1986, and any subsequent appeals, only those facilities with an approved CON will be authorized to conduct extrarenal organ transplantation procedures in Michigan. If a facility proceeds to engage in this new service witnout a certificate of need, it may be subject to injunctive action by the Attorney General's office at the request of the director of the Department.

Future direction

Although the basic structure for the designation of extrarenal transplant centers is now in place, the design and development of the Michigan Transplantation Services program has just begun. In response to the need for an indepth analysis of the issues related to organ transplantation, the Center for Public Policy Research on Organ Transplantation was established last year at the University of Michigan. (See related article, page 295.)

To help set priorities for the state as a whole and to provide advice to both the Center and the Department of Public Health, four statewide advisory committees have been established. The committees are broad-based, comprised of individuals with different types of experience in the area of organ transplantation. A number of physicians are included. The following four areas will be examined: public policy, ethics and social impact, public education, and the development of a statewide transplant registry. The Department is hopeful that by setting up these committees, communication among all parties interested in transplants will be enhanced.☐

By Rep. Richard Bandstra

"Required request" legislation should encourage donation

UNIFORM DONOR CARD

A bill currently pending in the legislature seeks to increase organ transplantation.

The number of people who could benefit by a transplant continues to grow. In Michigan and nationally, there are thousands of patients who could benefit from a kidney transplant. Hundreds more are awaiting transplants of hearts, livers, corneas and other tissues. Even though they are long, the waiting lists underestimate the problem since many likely recipients are not included.

More organs

The most effective solution to this problem seems simple: ask more people for authorization for an organ transplant. Public opinion polls consistently show that most people are in favor of donating organs for the benefit of someone else. In many cases, however, there are no procedures set up within the medical community to make sure that a request is made.

The proposed legislation, House Bill 4965, approaches this issue at the hospital level. Hospital personnel would be required to approach the family of a dying patient to see whether they would authorize the donation of organs for transplant purposes. Existing Michigan law allows family members to make that authorization for a loved one. However, often a family is not asked; hence, the "required request" provision of the new legislation.

It is, of course, important that the person making the request be empathetic to the needs of the family and knowledgeable about transplantation procedures. The proposed legislation authorizes the Michigan Department of Public Health to set up training standards to assure that the required request will not offend family members who are approached. Further, there will be absolutely no compulsion to authorize a donation; family members can simply decline a request if they so desire.

Similar legislation has been passed in New York, Oregon and California. Experience there indicates that required request legislation results in a doubling or tripling of the number of organs available for transplant. Further, the legislation is beneficial to donating families as well as potential organ recipients. Family members who authorize a donation often find that it lends a positive meaning to the death of a loved one.

I worked with representatives of the Michigan State Medical Society and the Michigan Hospital Association as well as other professional groups in developing the legislation. All interested parties are in support of the bill and final legislative approval is expected in the near future. The law is written to become effective ninety days after it is signed by the Governor.☐

Rep. Bandstra (R-Grand Rapids) is the sponsor of House Bill 4965.☐

By Sen. Gilbert J. DiNello

Joint committee engaged in transplantation fact-finding

One of the major advances in medical technology, organ transplantation, offers new hope and alternatives for those individuals with life threatening diseases. However, there are limitations to the availability and access to these very sophisticated and expensive medical procedures. Recognizing that there are public policy issues regarding these limitations to organ transplantation, Senate Majority Leader John Engler (R-Mt. Pleasant) established the Special Task Force on Michigan Organ Transplant Policy last fall.

I chair this task force and was given the charge of evaluating current programs and policies concerning the availability, financing and access to organ transplantation in Michigan. Shortly thereafter the House established a similar committee, chaired by Representative David Hollister (D-Lansing). Since both the House and Senate Special Committees intended to investigate current programs and policies, and would need to call upon the same resources within the state, it was decided the two committees would join forces during the preliminary fact-finding stages.

The first Joint Senate and House Committee meeting was held on February 13, 1986. The Joint Committee has conducted a total of five meetings covering topics such as: an overview of medical issues, financing of organ transplants, social and ethical issues and patient selection. The Joint Committee is planning two additional meetings to discuss organ procurement and organ transplantation facility personnel requirements. The Joint Committee has also requested that the Legislative Science office (Legislative Service Bureau) complete further research and prepare a report summarizing these issue areas of organ transplantation in Michigan, which should be available early this summer.

At each of the Joint Committee meetings, experts on organ transplantation have taken the time to prepare and present summaries of various topics concerning organ transplants. The Joint Committee is very grateful to those contributors, for without their assistance, our evaluation could not be complete.

Once the initial fact-finding effort is complete, the Joint Committee will split, with the respective House and Senate Committees pursuing their own deliberations. The Senate Special Task Force is anticipating completion of their deliberations at the end of June. At this time, findings and recommendations will be presented to Senator Engler. I anticipate that the Senate Special Task Force's recommendations will be presented in the form of proposed legislation to ensure Michigan residents the equality of access to transplant procedures.

Again, I would like to thank the Michigan State Medical Society and its members for their involvement with the Joint House and Senate Committee on Organ Transplants.☐

Senator DiNello (D-Detroit) is on the Senate Commerce and Senior Citizens and Social Services committees.

George D. Zuidema, MD

Organ transplantation data to be collected, analyzed

Zuidema

Since the first successful kidney transplant in 1953, the medical and scientific advances in transplantation have expanded in geometric proportions. Over 100,000 kidney transplants have been performed throughout the world, and transplants of the heart, heart/lung, liver, pancreas, lung, skin, cornea and bone marrow have been introduced. More recently, cross-species transplantation and transplantation of artificial devices have been utilized as alternative therapies to address the inadequate supply of human organs.

Increasingly, federal and state governments, insurance carriers, medical centers and public and private agencies are seeking to make informed and responsible decisions regarding how organ transplantation can provide the maximum benefits to society within a framework which assures equity to all potential recipients and in an era characterized by mandated limits on the growth of the total expenditures for health care in this country. Expansion of the health care delivery system that has occurred over the past two decades is being contained at the same time that expensive and major interventions, such as transplantation, are offering recipients increased quality of life and longer lifespans. As with other technologies that have made their way from the research milieu into clinical application, transplantation has become a part of sophisticated medical practice without full knowledge of the implications to the health care system and to society as a whole. It is now clear that the availability of organ donors and the pool of resources to support society's demand for organ transplantation are the key limiting factors that will govern to what extent and in what manner transplantation will become an accessible and viable part of the health care system.

Recognizing the need to address issues raised by organ transplantation in some rational and formalized manner, various state and federal agencies have commissioned such evaluative work to be done. These include NIH, the Battelle Institute and the state of Massachusetts.

Ongoing mechanisms

While these efforts are beginning to provide useful information regarding the clinical and social efficacy of organ transplantation, each is time-limited and focused on certain aspects of transplantation and none addresses issues specific to the state of Michigan. As transplantation continues to be woven into the fabric of the health care delivery system, it will be increasingly important to have in place ongoing mechanisms by which long-term evaluation and follow-up on all aspects of transplantation can be considered, investigated and reported. The pressure coming to bear in the public policy arena will not subside and clinical and social research will increasingly be required to provide the framework within which sound public policy can be formulated and rigorously evaluated.

Three hundred and fifty thousand dollars was appropriated by the state of Michigan to establish a Center for Public Policy Research on Organ Transplantation (CPPROT) at the University of Michigan. The objectives are as follows:

1. To collect and analyze data related to such public policy issues as total cost, cost-effectiveness of transplantation vis-a-vis alternative therapeutic measures, cost-benefit to society, the psychological and societal costs, attitudes and outcomes related to transplantation, quality of life issues, organ availablity and the needed health care delivery systems for organ transplantation.
2. To provide information and advice to the state, health agencies, transplant pro-

Continued on next page

Doctor Zuidema is vice provost for medical affairs at the University of Michigan.

grams, the public and other regional and national professional and public organizations as a framework within which public policy in transplantation can be formulated; and

3. To work in cooperation with existing agencies and groups so as to avoid duplication of existing capabilities and efforts.

Jeremiah Turcotte, MD, has been named director and a core staff is being appointed. The administration of the Center will work with four broadly representative advisory committees composed of transplantation experts, representatives of institutions that provide transplant services, and government, hospital and professional society officials. These committees already are actively working on assigned tasks. The committees are in the areas of ethics and social impact, public policy, tissue registry and education.

A scientific peer review committee will be established to provide oversight for proposed research projects. Responsibilities of the core staff include design and maintenance of the patient date registry, design of research projects, the actual conduct of some research, grant writing, design and distribution of educational materials, and liaison with transplant centers, MDPH, hospitals and others.

Cyclical planning

During the initial year of operation, the Center will focus on the areas of organization, education and development of a computerized registry. Coordination of research proposals and pursuit of additional sources of external funding will also occur during the first year to establish ongoing support for the Center's multiple objectives. Continuity in the planning, development and funding of the Center would be integral to its success and therefore a three-year cyclical planning effort is anticipated. The Center will be supported initially by the grant from the state of Michigan and from other external grants obtained from federal agencies, industry and philanthropic sources.

Turcotte

Rather than duplicating existing functions of the organ transplant network, the Center will serve as a central resource for the state working in cooperation with existing transplant organizations. Information currently collected by such organizations as the Transplantation Society of Michigan and the Michigan Kidney Registry can continue to be collected by those organizations and made available to the central data base at CPPROT as necessary thus avoiding any duplication. Additional information relating to extrarenal transplantation will be collected by the Center and made available to existing transplantation organizations.

Results of data collection and research efforts conducted by the Center, and any public policy recommendations emanating therefrom will be submitted to the state through the Public Health Advisory Council. In addition, the Center would serve as an ongoing resource to various state agencies on transplantation issues.

A promising future

The future of organ transplantation in the United States and throughout the world continues to be promising for those individuals for whom no other clinical treatment alternative exists. The evolution of successful kidney transplants has caused wide acceptance of transplantation as an effective approach to chronic disease. However, unlike diseases affecting most other organs, patients with end-stage renal disease have the option of alternative treatment patterns, i.e., dialysis and have enjoyed fully covered benefits for their chosen treatment mode through the federal government. It is not likely that the economic health of the nation will continue to permit such broad categorical coverage for transplantation of other organs, unless it can be demonstrated that transplantation provides obvious economic and social benefits over alternative treatments.

The introduction of extrarenal organ transplantation into the medical care system is being closely scrutinized. Will this new technology displace other medical services that have become the expectation for residents of the United States, and more importantly, will each have equal access for this life-saving potential? Finally, can the nation afford to embrace this treatment, and if so who will pay?

The Center for Public Policy Research on Organ Transplantation cannot provide the answers to all of these questions. It can, however, address these questions in an organized and systematic manner that will clarify the issues, organized and systematic manner that will clarify the issues, assist in the development of solutions, involve and educate the public and serve as a valuable resource to the state of Michigan in transplant planning and evaluation. Physicians and others interested in this issue can help by keeping informed on public policy development and by informing others, especially policy makers, of the importance of this issue.☐

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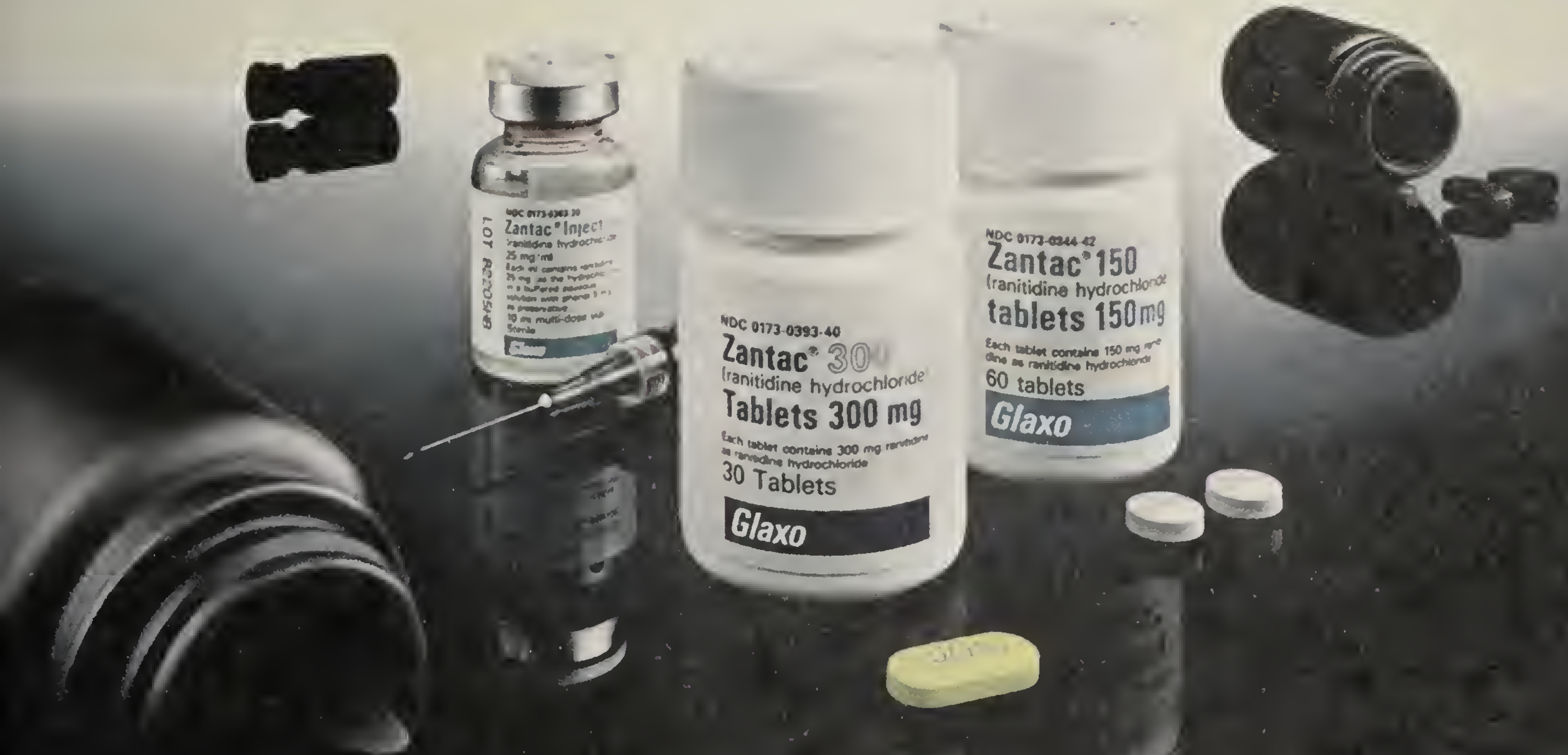
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May 1986

House of Delegates photo highlights

Gerald H. Mandell, MD, MSMS Speaker of the House, presided over the 1986 MSMS House of Delegates Meeting, May 2-4 at the Hyatt Regency Dearborn. The annual meeting drew hundreds of delegates representing physicians in every part of the state.

Robert D. Burton, MD, Grand Rapids, was re-elected vice-speaker of the House of Delegates.

Robert E. Paxton, MD, right, District 11 director from Fremont and former vice-chairman of the Board of Directors, was elected chairman of the Board during the annual meeting. Frank B. Walker, MD, Grosse Pte. Farms, was elected new vice-chairman (not pictured).

MSMS Legal Counsel Richard D. Weber, of Kerr, Russell and Weber, Detroit, briefed the delegates on the status of proposed professional liability legislation, the much-discussed Fleming Liability Trust Fund and the chiropractic lawsuit.

John J. Coury, MD, AMA president-elect and Port Huron general surgeon was a special guest at this year's meeting. During the proceedings Mrs. Dorie Coury was presented with a gift — a framed color photograph of her husband.

Rep. Richard Fitzpatrick (D-Battle Creek) was one of two lawmakers to address physicians during the MDPAC luncheon on Saturday. He identified six health care trends — "mega-medi-trends" — that "will provide challenges to political leaders of the next four years . . ." They are Cost, Chronicity, Consumerism, Conception, Computers and Corporations. (Look for the full text of Rep. Fitzpatrick's address in an upcoming issue of *Michigan Medicine.)*

The other speaker to address physicians during the MDPAC luncheon was Sen. Alan Cropsey (R-Dewitt). He has been a strong advocate of liability tort reform in Michigan, and congratulated physicians for their efforts to support legislation that is fair to both physicians and their patients. He encouraged them to continue to be active in the political process.

Fred Whitehouse, MD, Detroit, asks a question during a briefing by the MSMS Delegation to the AMA which immediately followed the MDPAC luncheon.

Carl A. Gagliardi, MD, Dearborn was named MSMS president-elect at the House of Delegates meeting. He had been 1985 chairman of the MSMS Board of Directors, and continues to be a leader in the MSMS drive for liability tort reform. He is shown here with District 10 Director Charles Oppy, MD, Roscommon (left).

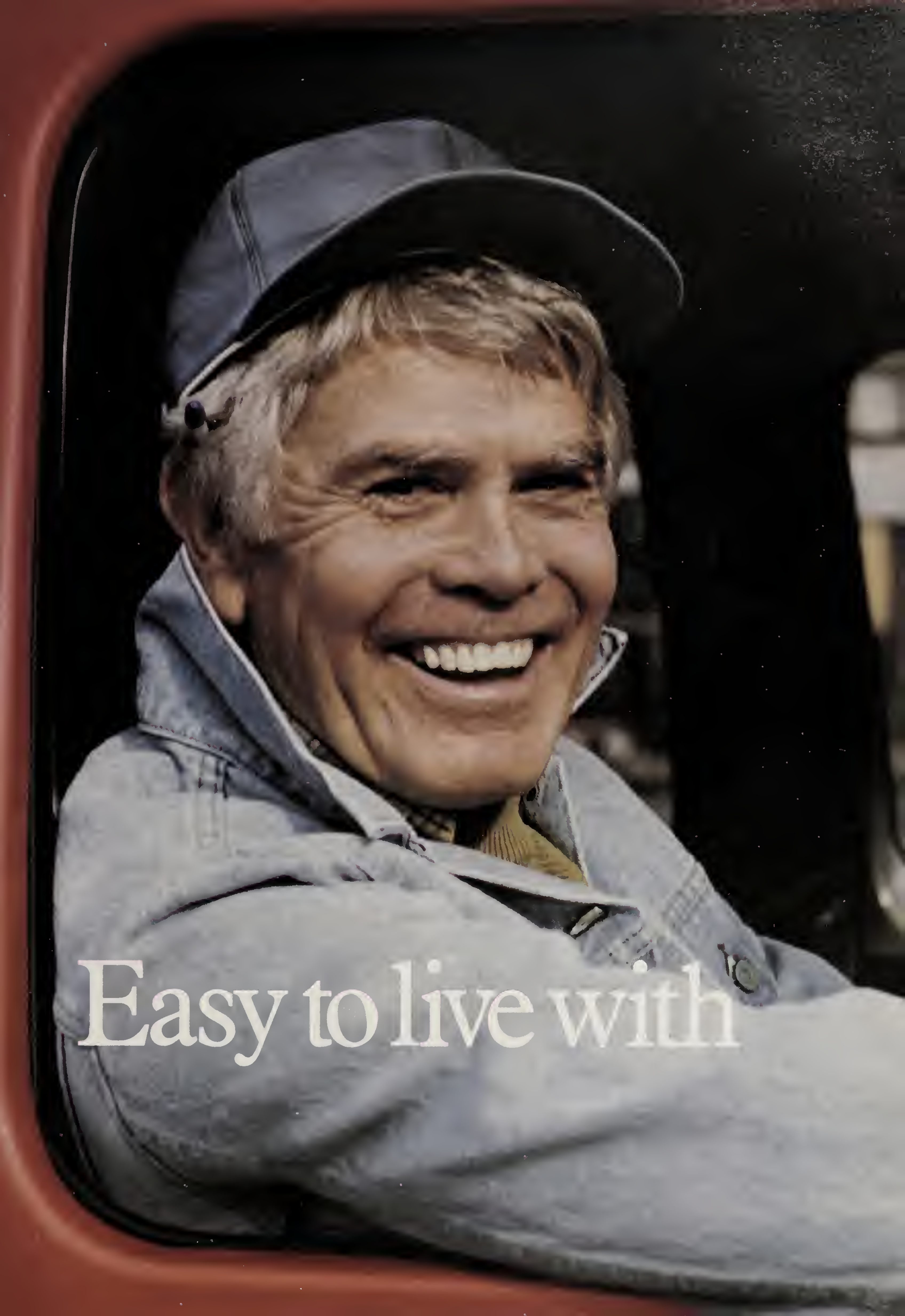
The majority of the work of the House of Delegates takes place in reference committees. Shown hammering out recommendations on the membership's resolutions are (left to right) W. Peter McCabe, MD; Gary Maynard, MD, and Anna Broecker, MD. The three served on Reference Committee D on Professional Liability, with Doctor McCabe as chairman.

Discussion of the issues doesn't end when the session does. Marguerite Shearer, MD, far left, makes a point to (left to right) Willard Stawski, MD, David Woodliff, MD and Mitchell Rinek, MD.

Richard J. McMurray, MD, outgoing MSMS president, gave an eloquent address to the delegate body as he completed a very challenging and productive year.

Thomas R. Berglund, MD, Portage, was named MSMS president for 1986. He had been chairman of the MSMS Board of Directors and is head of the American Medical Association Political Action Committee (AMPAC). He told the delegation that he is enthusiastic about the dynamic year ahead.

Representatives from the MSMS Resident Physician Section attended the House of Delegates meeting. Pictured above are Tim Kisabeth, MD and Walter Talamonti, MD, chairman of the Resident Physician Section. Another physician at far right refers to the text of a resolution.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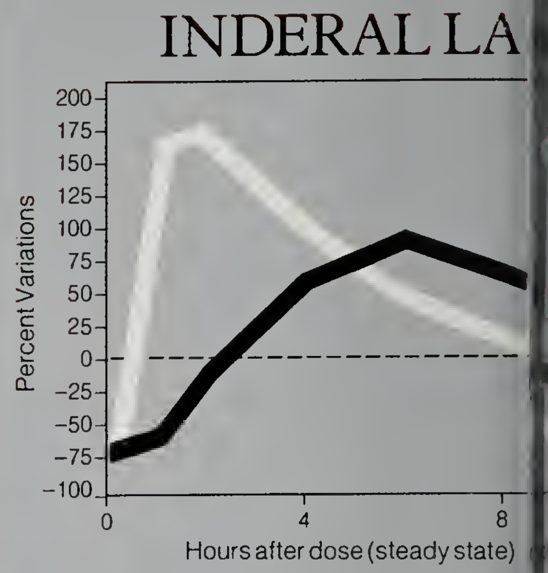

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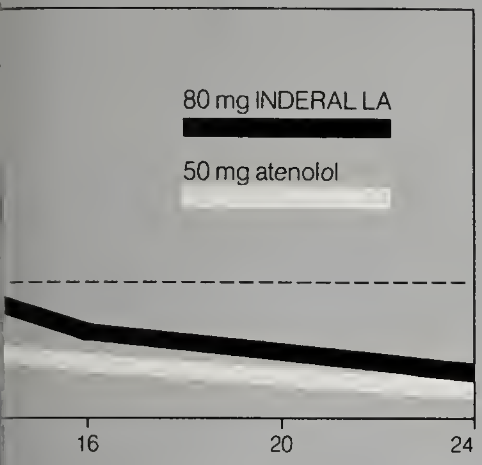

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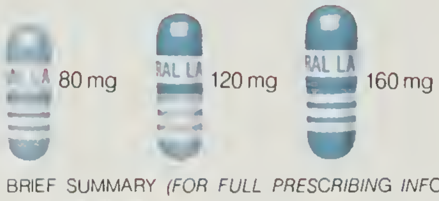

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CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL® LA): Propranolol is contraindicated in. 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs

WARNINGS

Propranolol hydrochloride (INDERAL® LA): CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or propranolol should be discontinued (gradually, if possible)

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction following *abrupt* discontinuance of propranolol therapy Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS INDERAL should be administered with caution, since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported

PRECAUTIONS

Propranolol hydrochloride (INDERAL® LA): GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test Withdrawal may lead to a return of increased intraocular pressure

CLINICAL LABORATORY TESTS Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs, such as reserpine should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity There were no drug-related tumorigenic effects at any of the dosage levels Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug

PREGNANCY Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

NURSING MOTHERS: Propranolol is excreted in human milk. Caution should be exercised whe propranolol is administered to a nursing mother.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

Hydrochlorothiazide: GENERAL: Periodic determination of serum electrolytes to dete possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electroly imbalance, namely Hyponatremia, hypochloremic alkalosis, and hypokalemia Serum and uri electrolyte determinations are particularly important when the patient is vomiting excessively receiving parenteral fluids. Medication such as digitalis may also influence serum electrolyte Warning signs irrespective of cause are. Dryness of mouth, thirst, weakness, lethargy, drowsines restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, a gastrointestinal disturbances such as nausea and vomiting

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, during concomitant use of corticosteroids or ACTH

Interference with adequate oral electrolyte intake will also contribute to hypokalemia Hyp kalemia can sensitize or exaggerate the response of the heart to the toxic effect of digital (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassiu supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, exce under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occ in edematous patients in hot weather; appropriate therapy is water restriction, rather than admini tration of salt, except in rare instances when the hyponatremia is life-threatening In actual s depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazi therapy

Insulin requirements in diabetic patients may be increased, decreased, or unchanged Diabet mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuret therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland wi hypercalcemia and hypophosphatemia have been observed in a few patients on prolong thiazide therapy. The common complications of hyperparathyroidism, such as renal lithiasis, bo resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued befo carrying out tests for parathyroid function.

DRUG INTERACTIONS: Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patie Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficie to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY. Pregnancy Category C. Thiazides cross the placental barrier and appear in co blood The use of thiazides in pregnancy requires that the anticipated benefit be weighed again possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopen and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS. Thiazides appear in human milk. If use of the drug is deemed essenti the patient should stop nursing.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL® LA): Most adverse effects have been mild a transient and have rarely required the withdrawal of therapy

Cardiovascular Bradycardia, congestive heart failure; intensification of AV block; hypotensio paresthesia of hands, thrombocytopenic purpura; arterial insufficiency, usually of the Rayna type.

Central Nervous System Lightheadedness; mental depression manifested by insomn lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; vis disturbances; hallucinations; an acute reversible syndrome characterized by disorientation time and place; short-term memory loss; emotional lability; slightly clouded sensorium; a decreased performance on neuropsychometrics

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, cons pation; mesenteric arterial thrombosis; ischemic colitis.

Allergic: Pharyngitis and agranulocytosis; erythematous rash; fever combined with aching a sore throat, laryngospasm and respiratory distress.

Respiratory Bronchospasm.

Hematologic: Agranulocytosis; nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported

Miscellaneous Alopecia, LE-like reactions; psoriasiform rashes; dry eyes; male impotence; a Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the sk serous membranes, and conjunctivae reported for a beta blocker (practolol) have not be associated with propranolol

Hydrochlorothiazide:

Gastrointestinal. Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipati jaundice (intrahepatic cholestatic jaundice); pancreatitis; sialadenitis.

Central Nervous System Dizziness, vertigo; paresthesias; headache; xanthopsia

Hematologic: Leukopenia, agranulocytosis; thrombocytopenia, aplastic anemia.

Cardiovascular: Orthostatic hypotension (may be aggravated by alcohol, barbiturates, narcotics)

Hypersensitivity: Purpura, photosensitivity; rash; urticaria; necrotizing angiitis (vascul cutaneous vasculitis); fever; respiratory distress, including pneumonitis; anaphylactic reactions

Other: Hyperglycemia, glycosuria, hyperuricemia, muscle spasm; weakness; restlessne transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced therapy withdrawn

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1. Data on file, Ayerst Laboratories. **2.** Ravid M, Lang R, Jutrin I The relative antihypertens potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily *Arch Intern M* 1985;145 1321-1323. **3.** Sumiye L, Vivian AS, Frisof KB, et al: Potassium loss associated w hydrochlorothiazide versus chlorthalidone. *Clin Ther* 1981,4.308-320. **4.** Ram CVS, Garrett E Kaplan NM. Moderate sodium restriction and various diuretics in the treatment of hypertensi *Arch Intern Med* 1981,141:1015-1019

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Recent Medicare changes summarized here

The following MSMS Department of Medical Economics and Physician/Hospital Relations Informational Report to the MSMS Board of Directors is reprinted here to update members on recent Medicare changes:

The Consolidated Omnibus Budget Reduction Act (COBRA) of 1986 recently passed by Congress contains more than 50 Medicare changes. The legislation reduces Medicare outlays by $460 million for the remainder of the fiscal year and by about $6.9 billion during the next two fiscal years. One of the significant provisions of COBRA is the lifting of the fee freeze and a 4 percent increase in prevailing fee screens for participating physicians on May 1, 1986. The freeze on any fee increases for non-participating physicians is extended until December 31, 1986.

Carriers were directed to provide individual physicians with all information they request about their current Medicare profiles (their recorded customary and actual charges) and the prevailing fees for specific medical services in their area. This information will be provided only upon written request.

Other relevant changes follow:

- Beginning January 1, 1987, Medicare payments for laboratory services provided in a physician's office will be made only on the basis of an assignment.
- Extends for one year (except in Oregon) the transition to national DRG rates under the Prospective Payment System (PPS). The FY86 DRG

Continued on next page

rate for each hospital will be 45 percent hospital specific and 55 percent federal specific. For FY87 the blend will be 25 percent hospital specific and 75 percent federal. Effective with discharges on May 1, and through October 1, the federal rate component will be 75 percent regional and 25 percent national. On FY87 discharges the component will be half federal, half regional.

- From May 1, 1986, to October 1, 1988, the Medicare adjustment for indirect Graduate Medical Education (GME) costs will be reduced to 8.1 percent. There will be a one percent increase in payments for direct GME costs. Under a formula change support for post-graduate training will be limited to the number of years required for initial board certification, plus one year.
- PROs will be required to do pre-procedure review (for every patient) on at lease 10 elective surgical procedures. They will have authority to approve or disapprove a procedure, but also will have discretion to require a second opinion and permit the beneficiary to decide, and based on the findings, whether to undergo the procedure. HMO and CMP services also must be reviewed starting January 1.
- Penalties are established for hospitals that transfer patients without adequate medical screening and stabilization. Physicians involved in such transfers also can be penalized.
- Coverage for assistants at surgery in certain cataract operations will be limited to situations where the PRO or carrier has approved such use because of medical necessity. Unless preapproved, billing patients for assistants' services also is prohibited. Payments for post-cataract surgery also will be limited. Separate payment determinations must be made for prosthetic lenses and and related professional services. Inherent reasonable guidelines will be applicable in determining payments for prosthetic lenses.
- Additional PPS payments are mandated for hospitals that serve a disproportionately large share of low-income patients.

A Physicians Payment Review Commission (PhysPRC) will be established within the Office of Technology Asessent. The 11-member commission comprised of physicians, allied health professionals and health care economists will recommend physician payment levels to Congress.

Also recently released was a new report from the Office of Inspector General on premature hospital discharges and inappropriate transfers. The overall extent of the problem is still not fully known. The study conducted from October 1, 1983, to May 31, 1985, reported on 4,724 cases. Of those reviewed, 82 percent were premature discharges and 145 were inappropriate transfers. The data was not complete due to the phasing out of PSROs, HCFA's inconsistent instructions, and inaccurate PRO reporting.

HCFA Acting Administrator Henry Desmarais said, "Corrective action will be taken against any PROs unable or unwilling to monitor quality of care." To date seven PROs in the states of Alabama, Delaware, Kansas, Kentucky, Tennessee, Utah and Wisconsin have received non-renewal notices from HCFA.☐

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By Carole Eberly

Sen. Miller calls liability "toughest" issue in nine years

Although he is confident a short-term solution has been reached, he believes the liability insurance area is due for an overhaul.

A state senate leader has some words of warning for physicians expecting to see a reduction in malpractice insurance premiums because of recent liability legislation.

"I think there is a serious misconception that when the bill passed, it would reduce insurance premiums," said Senate Democratic Leader Arthur Miller (D-Warren). "I don't see any reduction in insurance premiums. The best thing I would claim is that at least it might stabilize them, preserving the status quo."

Miller, who wrestled with the legislation with other legislative leaders and Governor Blanchard's assistants over the past year, said the issue was one of the toughest he has faced in his nine-year tenure in the Senate.

And although he is confident a short-term solution has been reached, he believes the liability insurance area is due for an overhaul.

"We have to look at ways we can broaden competition in the insurance industry so we can at least bring about competition among the major insurance carriers so doctors can shop for a fair price," he said.

Miller was not convinced there is open and fair competition for physicians to acquire affordable and available insurance. He said the problem would be looked at "down the road."

"I don't think we'll see any reduction in premiums until there is a more eager form of competition among carriers who offer this coverage," he maintained.

In the minority

Miller, a legislative workaholic who claims to putting in 110 percent of his time in Lansing solving legislative problems, said being a Senate Democrat the past two years has been frustrating.

Ms. Eberly is a Lansing-area freelance writer.

It was in 1984 that two Democrats lost their seats to Republicans during recall elections over the state income tax hike. As a result, Democrats had to give up their committee chairmanships to Republicans—a bitter pill to swallow.

"As a minority member, you no longer have the authority to schedule committee hearings and report out legislation," said Miller, who was chairman of the Senate Commerce Committee. "It's very frustrating after being in the majority and after having the title of chairman to be just a minority member, or person who still contributes a lot to legislation, but by no means has the power to report legislation to the entire Senate body."

Miller, 39, was chosen for the Senate post by his Democratic colleagues last year, following the decision by Senator William Faust, Westland, to step down after years of holding the position. Miller, like Faust, was elected on his ability to get along well with everyone—not only members of his own caucus, but Republicans as well. Miller not only has to deal with 37 Senate egos, but House Speaker Gary Owen (D-Ypsilanti) and Blanchard's representatives.

Miller admits keeping harmony and teamwork in a minority group is a fulltime job.

"Sometimes I wonder if I had some pins and juggled them or maybe used a Ouija board, I could let them make the decisions," he said.

But, he said, the Senate Democrats are using good defensive strategy in keeping legislation moving and the Republicans on their toes.

Senate Republican Leader John Engler has 20 GOP members to the Democratic count of 18.

"The numbers are close," he said. "In a lot of cases, he's short a member or two on a vote. It takes bi-partisan cooperation and I think we've moved a lot of bills in the Senate. There have been some struggles and arm-twisting, but we've been able to maintain our position."

A turnaround?

Will the Senate number turn around after this fall's election? Miller smells blood.

"I think the Democrats have an outstanding opportunity to win back the majority," Miller said.

He explained that the two seats lost during the recall have a real possibility of ending up in the Democratic camp. In addition, the retirement of veteran GOP Senator Harry DeMaso of Battle Creek presents another bright spot for the Democrats.

As far as Miller's seat goes, he says his district votes 70-75 percent Democratic—a solid winner for him. However, he takes nothing for granted, knocking on about 10,000 doors each summer.

"I work the district very hard during summers, not just during election years," he said. "I believe in maintaining good communications with voters throughout my term in office."

If he works hard keeping in touch with his voters and keeping his caucus members in line, he works equally as hard maintaining his family life.

"I look around me and I tell myself that this Capitol building was here long before I was born and it's going to be here long after I leave," he said. "So my perspective is I put 110 percent in while I'm in Lansing representing the people from the 27th District. But I always keep in mind this building will be here long after Art Miller goes and the world will continue to go around."

Miller, who has a wife and four children at home, tries to spend as much time as possible with his family on weekends. That time may entail anything from a school program to a Hulk Hogan wrestling match at Joe Louis Arena.

But now Miller is sitting at a conference table in his office that has been the scene of countless negotiations. Behind him is a picture-window view of the Capitol's front lawn. Calmly smoking a cigarette, he had a few words of advice for physicians wondering how to get their views across to legislators.

"I recommend they take the time throughout the year to break bread for breakfast, lunch or dinner with their senator or representative," he said. "Take the time to get to know them, to meet with them, talk to them, let them know who you are.

"These are people who deliver health care services to make sure my constituients stay healthy," he added. "I welcome their input throughout the year, not just during a 12th hour crisis. I want to know who that person is, rather than receive a form letter."☐

By June E. Osborn, MD
Ann Arbor

The AIDS epidemic: multidisciplinary trouble

The following article is reprinted at the suggestion of Susan Adelman, MD, member, MSMS Board of Directors and chairperson, MSMS Subcommittee on Public Service, and with permission from the *New England Journal of Medicine,* Vol. 314, No. 12, March 20, 1986.

In this essay I shall try to summarize in mid-course the status of a unique series of events in human history, which involves virtually all facets of modern knowledge but is usually referred to simply as the acquired immunodeficiency syndrome (AIDS) epidemic. Humanity has embarked on a mortal race with a novel pathogen of great subtlety. If this were ancient Greece and I an oracle, my task would be simpler. The fiendishness implicit in the mode of pathogenicity of the AIDS virus could be appreciated as eminently suitable for an instrument of the gods, and the potential inadequacy of society's response to the epidemic would be deemed appropriate punishment for the hubris that allowed the natural sciences to get so far ahead of the social and behavioral sciences. Perhaps the fact that would most amuse the gods is the ostensible ease of preventing further spread: the virus causing AIDS is, for the moment, a pathogenetic weakling that is truly difficult to transmit except by sexual routes.

But, knowing what we know, we cripple ourselves in Sophoclean fashion. The people at greatest risk of becoming infected—homosexual men—have been beleaguered by society to such an extent that they may evade or ignore the efforts to control the spread of AIDS. The members of the second highest risk group—intravenous drug abusers—have already said goodbye to cautious mores and are probably refractory to instructions concerning their own salvation, let alone that of others.

And the people in charge have a truncated vocabulary: the very messages that we must broadcast in order to abort the epidemic and buy time for further scientific advance require the use of words that are taboo in high places. We need urgently to pursue so-called psychosocial research—but we may not be "explicit," and we may not, in fact, send out messages that even seem to condone sexual and other practices that deviate from a governmentally sanctioned norm. No official document should use the phrase "safe sex," even if that currently appears to be the major promising route to safety for an important segment of the population. Well may the gods laugh!

We in the United States have a world-class epidemic on our hands, which we have exported so effectively that the rest of the world is only a little bit behind us. The 14,000 Americans in whom AIDS has been diagnosed to date are only the most unlucky of the more than half a million people in the United States who are already infected with the new virus, and yet the first round of cases has already strained our human and societal resources. Nearly half of those diagnosed as having AIDS are dead, and their deaths have been distinctly unpeaceful. A few of

Continued on page 312

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them were unfortunate souls who needed blood transfusions, usually for urgent surgical reasons, which turned out to be the vehicle for viral transmission. Others were embarked on an illegal dash to intravenous chemical suicide, which was only hastened by microbial intervention. But most of them were talented young men who had chosen atypical life styles for their own personal—perhaps biologic— reasons. We should remind ourselves that among the dying may be the Tchaikovskys and Prousts of our time—dying before the flower of their creativity has enjoyed even brief bloom.

The outlines of the economic impact of the epidemic are just beginning to emerge, and the specter is terrible to contemplate. It is useful, in order to appreciate the economic trouble to come, to think of *every single case* of AIDS as costing the same as a heart transplantation, and for roughly the same reasons. By unhappy chance, the health care industry had been launched by Congress into a vigorous effort at cost containment through the vehicle of diagnosis-related groups (DRGs) just before the gods struck! My economist friends tell me that the strategy for creating a DRG for AIDS has yet to be designed and the situation is fairly chaotic at present. If we sense trouble now, however, we should remember that a substantial fraction of the patients who have already been given the diagnosis of AIDS have died, and so the anticipated doubling in numbers of patients diagnosed in the next year will have far more than twice the impact on the health care industry—all the more so, since the majority of cases are concentrated in just a few cities. No tropical storm has the economically devastating potential of the new cases of AIDS expected in the next few years, and yet I have read only an occasional suggestion that disaster funds should be made available for the AIDS hurricane now gathering force.

There is a politically interesting aspect of the epidemic that has thus far been mercifully obscure. Although the virus causing AIDS is surely American by adoption, not by birth (the most likely location of transfer to the human species is in Central Africa), the epidemic is indeed all-American in its initial dissemination. Most of the rest of the world is catching up with us, with a lag time of two or three years, but the exportations from the United States are easily tracked. We are indeed one world in operational —if not in peaceful—terms. A recent paper from Japan, for instance, documented the absence of antibody from a number of Japanese groups, including homosexuals, but reported 27 percent seropositivity among patients with hemophilia, which was directly related to the American source of the factor VIII and IX concentrates used to treat them. The introduction of AIDS into Denmark and Australia was readily traceable to the return of homosexual men from vacations in New York and San Francisco.

Even the presence of the poor Haitians in the high-risk category may reflect the penchant of American homosexual men for vacationing in Haiti, coupled with the dire poverty that makes prostitution a frequent means of subsistence survival for Haitian adolescents of either sex. A recent analysis of the distribution of infection in Haiti showed a typical frequency of human T-cell lymphotropic virus, Type III, antibody in the general population, contrasting with a markedly higher frequency in areas known to be centers for prostitution, male and female alike.

Scientifically, the news is better; in fact, the news would be really good if we were more able to put known facts to use. The progress of biomedical science in the forced march of the AIDS epidemic has been truly spectacular and is worthy of admiration and, I suppose, a bit of international self-congratulation. Extraordinary scientific effort does not always lead to extraordinary progress, but in this case it has. Witness the incredible speed with which the virus was isolated—in three separate laboratories in France and the United States. Note also that less than a year elapsed from viral isolation and establishment of a highly productive cell-culture system to systematic and thorough screening of blood on a massive scale. Reassuringly, the entire enterprise was carefully monitored and regulated by a state-of-the-art cadre of scientists at the Food and Drug Administration. Those are scientific and logistic accomplishments of unprecedented magnitude. I think it is safe to say that humankind has never responded so quickly and thus far so effectively to a novel medical challenge.

It is interesting to note that the science leading up to the recognition of the epidemic represented very recent advances in immunology, including definition of lymphocyte subsets, sophisticated analyses of T-cell physiology, and elegant dissection of lymphokines and their roles in response to diverse stimuli and stresses. As it turns out, the immune response is an exquisitely modulated system of checks and balances, and yet without the insights derived from the immunologic advances of the 60s and 70s, we might have

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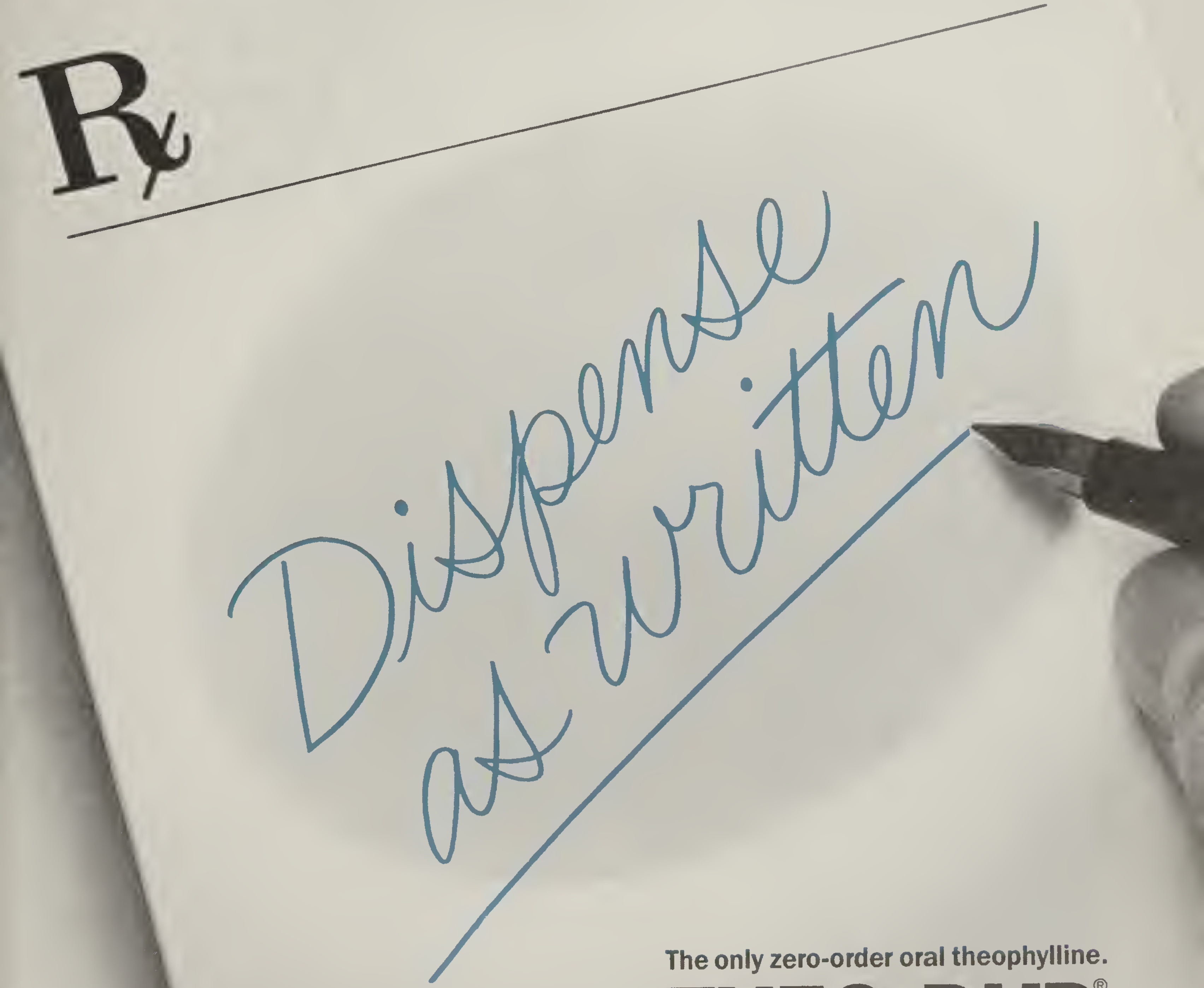

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failed to identify AIDS for a dangerously long period. A colleague of mine has a little sign on his bulletin board that says, "The first step to solving a problem is to see it clearly." I believe we should all feel some reassurance that the technologic advances of the past two or three decades are at least allowing us to see this problem clearly in scientific terms.

First of all, the AIDS virus is really a poor pathogen in terms of its communicability. The human race would be gone by now if syphilis had been more adept at dissemination, and the AIDS virus is even less effectual in that heterosexual transmission is inefficient. If we could put into action the knowledge we have gained from epidemiologic study, we could forecast an end to the trouble, or at least an end to the further spread of the virus. However, we must keep in mind that the AIDS virus is a new pathogen; although the general trend of new human microbes is thought to be toward settling down and domesticating further, we have almost no experience to justify that theoretical expectation. On evolutionary grounds, it behooves a successful parasite not to "make waves," and with that in mind one could argue that the new virus is likely to become less transmissible and less virulent. But evolution takes a very long time, and humanity has known this virus for less than 30 years.

Turning to virology and immunology, hopes and possible disappointments loom in equal measure. Animal models of retrovirus vaccines have begun to show some promise: with ornate chemical manipulation one can create a subunit vaccine of feline leukemia virus that will protect kittens against future viral challenge. But the virus of AIDS has some nasty properties, even for a retrovirus. Like Kipling's leopard, it changes its antigenic spots at frequent intervals, perhaps enough to evade previously evoked immune responses. That kind of antigenic variation is familiar to students of the parasitic world; many of the pervasive and successful eukaryotic parasites of humans have antigenic variation as a major pathogenetic mechanism. But the public is accustomed to more stable viral threats; the viruses causing measles, mumps, polio, and rabies all vary slightly at the molecular level but, mercifully have remained in categorically exact array for purposes of vaccines. Not so the new retrovirus, and thus a new variable must be introduced into vaccine parlance.

Another worry lies in the relative difficulty of identifying antibodies that actually neutralize the virus of AIDS (the antibodies measured in the test now used are indicative of viral infection but are very weak in their capacity to render the virus noninfectious). It is possible that monoclonal technology will help to identify epitopes on parts of antigenic molecules that pervade the immune response to many variants and might be more effective in neutralization. There are precedents for those situations in other retrovirus infections, and I have confidence that solutions can be found, but the science isn't easy, to say the least. Before I leave the topic of potential vaccines, however, I must make two further points, one scientific and one practical. Scientifically, there is a fundamental cause for concern about a vaccine for the virus, since the cellular receptor that the virus required to initiate infection is in fact the receptor for the T-cell antigen. The reason for the devastation of AIDS is the lethal viral effect on T-cells, which are required for an effective immune response to foreign antigens, and one must be careful not to harm those cells in attempting immunization.

On a practical note, there is room for much skepticism about the advent of a vaccine any time soon. Even if a vaccine were at hand, the logistics of testing it would be hard to imagine. In order to establish protective efficacy, one would need a group of willing, thoroughly informed research subjects at high risk but as yet unexposed. The slowness of the viral infection would make assessment of both efficacy and safety a tremendous challenge, and the liability problems would be vast. Who would want to manufacture such a vaccine? To whom would it be given? High-risk groups? The general public? If we can't cope with pertussis, how can we manage a vaccine for the AIDS virus? Remembering the attempted mass immunization against swine flu, many of us shiver when the possibility of a vaccine is regarded as a panacea.

Let us turn now to hopes for treatment and cure. For those already ill with AIDS, the AIDS-related complex, or the lymphadenopathy syndrome, much of the damage is done. The DNA equivalent of the viral genome is intricately woven into their own cellular DNA, and their immune systems have been wounded, possibly beyond repair. There have been some elegant efforts to reconstitute or augment what is left of these patients' immune responsiveness, but the results have not been encouraging. I believe that the largest hope for intervention lies in understanding the role of various cofactors in determining whether a person remains asymptomatically

Continued on next page

infected or goes on to the development of lethal disease. From the beginning of the epidemic there have been hints that other infections, drugs, and life-style characteristics have contributed to the occurrence of AIDS in the populations at highest risk, and it will be crucial to understand the importance of such factors in order to counsel the hundreds of thousands of people we believe to be asymptomatically infected at present.

I realize that my remarks are gloomy, but I do believe we are in serious trouble. However, some events of the past few years are sources of optimism. First, the perceived impossibility of behavioral modification has been given the lie by the sharp downturn in indicator infections, such as gonorrhea, in homosexual populations in recent months. Second, assuming that we can get the present epidemic under control, much of the scientific progress made under such urgent conditions is likely to be relevant in other biomedical contexts. Intensive study of the retroviruses has yielded insights about oncogenes, cellular and molecular replication, and malignant change that may have a huge yield in our understanding of cancer and of cellular differentiation. Information gleaned from increasingly fine dissection of the immune response is already proving useful in analyses of aging. Some of the chronic diseases most frustrating to researchers, such as rheumatoid arthritis and lupus erythematosus, may be close to yielding to the advances spinning off from research on AIDS. And finally, the observation that the AIDS virus takes privileged sanctuary in the central nervous system may add insight about the causes of chronic neurologic diseases.

In the meantime, we must communicate patiently and clearly to a frightened public what we know and what we are learning. As always happens in times of panic, fringe groups are arising to raise the level of static and make the message hard to hear, and we will have to shout our message of prevention. The ongoing epidemic of smoking has taught us that prevention as a strategy is peculiarly hard to sell as long as treatment and cure are bandied about as alternatives, so we must be very sure not to dilute the message with false or distant hopes.

Once again, preventive medicine—in its drab and unattractive garb—turns out to be the solution. I often like to point out that, if you "do" preventive medicine and public health exactly right, exactly nothing happens and things are very dull. Let us all pray for a little boredom.☐

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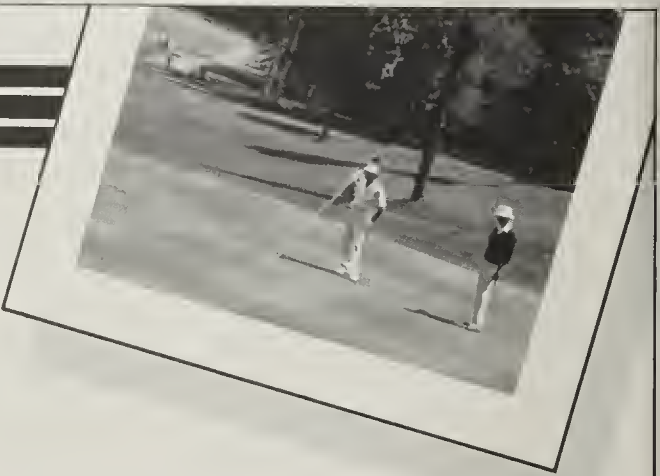

ain drug dosages

researcher hopes to learn nore about the optimum losages of pain killers by tudying hospital patients who elf-medicate with injectable arcotics.

Terry J. Baumann, PhD, assisant professor of pharmacy ractice at Wayne State Uniersity is evaluating how paients who are hooked up to pecial drug-dispensing nachines administer their pain illers. From this, Baumann opes to determine the drug losages that will be most eneficial to patients throughut their recoveries.

Patient-controlled analgesia PCA) is relatively new to the nedical profession. Baumann irst began studying prototypes or the drug dispensing machine nly three-and-a-half years go. Many hospitals, now rouinely see PCA as an alternative to the traditional procedure of the nurse administering the drug.

The system works by allowing the patient to almost completely manage his or her pain, Baumann said. With PCA, a nurse hooks up the patient to the drug dispenser. A physician determines the dosage and minimum time interval between doses. "By pushing a button, the patient can administer a preset amount of narcotics (provided the minimum time interval has passed)," Baumann explained.

"It's my feeling that pain is subjective," the WSU pharmacist said. "The patient knows pain better than anyone else does. That's why this works."

Baumann and others'' studies of patient-controlled analgesia show that it is a good alternative to traditional drug injections.

One of its greatest advantages is that the patient can receive pain relief almost whenever he or she needs it. "With the nurse administering the narcotic, it may be 30 to 45 minutes between the time the nurse can get it to him," Baumann said. He explained that the lengthy time period is caused partly by the nurse's busy schedule and partly by the number of steps the nurse must take before she can give the patient the drug.

Another problem with the traditional method is that patients receive large quantities of drugs infrequently. "Most of the time, the patient is either heavily sedated or in pain," Baumann said. With PCA, the patient receives a little pain killer much more often and maintains a balance between sedation and pain.

PCA's flexibility also permits

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patients to reduce the number of doses as they recover.

Because of the built-in limits on the amount of drug that can be taken, "patients (in control of their drugs) are very unlikely to develop an addiction to narcotic analgesics," Baumann said, citing various studies. In fact, when compared to the traditional intramuscular injections, "It's safer and the patients may use less drugs in some instances.

Human skin cultures refined

University of Michigan scientists have developed a new way to grow the cells from the outer layer of human skin in a laboratory dish so toxicity and radiation tests can be performed on the tissue culture instead of on animals.

Standard cultures from the cells of the outer layer of the skin, or epidermis, have been inadequate for such tests because they are grown submerged in a fluid, which is not the natural environment for skin and limits the use of the tissue in laboratory experiments.

The U-M tissue culture begins submerged, where it grows for seven to 14 days. Then the liquid level is lowered so that the top surface of the culture is exposed to the air, simulating the natural environment for epidermis, the body's natural barrier between the air and body fluids. The paper-thin culture is allowed to grow for another 14 days with the top exposed to the air and the bottom resting on a moist glass fiber pad.

Because it is exposed to the air, the culture can behave as natural epidermis and react to stresses in the same way as natural skin. It is not designed to be returned to patients as a graft to treat burns.

Toxicity tests performed on the tissue culture would show exactly how human skin responds without having to expose people to the substance.

Since the culture is taken from human skin, it will respond as the skin of the individual donor, an asset in helping to determine safe levels of exposure of an individual to harsh or toxic substances.

Head injury cooperative

Four state government department leaders have joined with two private Michigan associations to promote improved services for people with traumatic brain injury.

Signing a cooperative agreement to improve research, education, and rehabilitation services for people with serious head injuries were Superintendent of Public Instruction Phillip E. Runkel; Agnes Mansour, director of the Department of Social Services; C. Patrick Babcock, director of the Department of Mental Health; Gloria Smith, director of the Department of Public Health; Sharon Barefoot, president of the Michigan Head Injury Alliance; and David Smith, executive director of the Michigan Association of Rehabilitation Facilities.

Runkel said that while head injury has been a serious disability for years, it is only recently that its full effects on the individual have become known.

Many behaviors of head injured persons that were once attributed to psychological factors are now found to be related to the physical disability, Runkel said.

"We believe it is necessary to create an awareness of the true cause and effects of traumatic brain injury as a first step in training professionals within the education, rehabilitation, health, and social service systems," he said.

The cooperative agreement calls for:

- Recognition of traumatic brain injury as a specific diagnostic category to enable individuals to be served by existing state and local programs;
- Development of a knowledge base concerning the characteristics of head injured persons and the types of treatment available; and
- Expansion of public and private policy affecting services for persons with traumatic brain injury.

An action plan defining work steps relating to these and other specific goals will be developed within a 12-month period and will be reviewed annually and updated as necessary.

Altering genetic material to produce insulin

A geneticist at Wayne State University is working on a method to "grow" insulin, certain hormones, and insect toxins in plants.

Albert Siegel, PhD, a biology professor from Detroit, is just a few steps away from being able to genetically insert desired traits into viruses, which will spread the trait by infecting plants. Scientists can then "harvest" the trait's product.

"We're working on a novel method for integrating genetic information into a plant," Siegel explained. This method involves replacing one gene with another that carries a chosen trait. The variety of genes that can be inserted is almost limitless, Siegel believes, and includes those that produce insulin, human growth hormones, insect toxins, and increased nutritional value in plants. "Many of the animal proteins, such as insulin, are already being mass produced by bacteria," Siegel said, "but the method we're using would eliminate some of the problems that have been encountered when using bacteria."

His work could be particularly beneficial in increasing nutritional value in plants. Siegel explained that corn, for instance, is deficient in two of the amino acids that humans need. Using the insertion method, he said he may be able to add the missing amino acids.

Siegel began studying this unique genetic method five years ago. He chose tobacco rattle virus for his experiment because it has several properties that make it particularly suited for development into a "vector" for introducing foreign genetic

Continued on next page

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material into plants. This vector, however, will not alter the plant's genetic material nor will it allow the infectious material to spread in the field.

The genetic material in tobacco rattle virus is split into two molecules of RNA—a short one and a long one—and he found that he could alter the short one without destroying the virus' vital functions. In his experiment, he is replacing the virus' ability to make the protein that packages its RNA into virus particles with other genetic information, such as production of insect toxin or insulin. Without the packaging protein, the virus' genetic material will be unable to spread from plant to plant, but will be able to spread within a single plant. Siegel wanted both these features.

He is using bacteria in his efforts to alter the short RNA.

"First, we convert the short RNA to DNA and insert it into a plasmid," Siegel said. The plasmid (a small circle of DNA) can replicate to high levels in bacteria. "Then, we alter the DNA copy of the short RNA and make new altered RNA from it. We insert the new altered RNA together with the unaltered long RNA into plants where it spreads and hopefully results in a functional gene product," he said. Siegel believes he will be able to proceed with the altered replicating RNA within a few months.

From there, he hopes to be "growing" insulin, growth hormones and plant toxins, and improving the nutritional quality of plant proteins, perhaps as early as a year from now.

Genetic discovery detects heart disease

A new genetic finding could have a major impact on the way people are diagnosed for heart disease by identifying those at risk well before any symptoms occur.

An estimated 4.6 million Americans suffer from coronary artery disease. The most common form, atherosclerosis, is caused by a buildup of cholesterol in the arteries which restricts blood flow and often leads to heart attacks. A large percentage of those affected may be "genetically predisposed" to coronary artery disease, according to geneticist Robert Norum, PhD, of Henry Ford Hospital.

The genetic link was identified in two sisters whose atherosclerosis was not apparent from blood tests that normally indicate the amount of cholestrol in the blood. Their overall blood cholestrol was normal but they had low levels of the cholestrol HDL (high-density lipoprotein). HDL is known as a "good" cholestrol because it removes used cholestrol from the blood.

Further investigation by Doctor Norum and his colleagues revealed that both sisters were missing a protein (apo A-I) which is vital in removing excess cholesterol from the arteries. Their theory that this disease was caused by a genetic abnormality was later confirmed by researchers at Harvard University who used DNA methods to trace the mutation. As recently reported in the Wall Street Journal, it was the first atherosclerotic disease diagnosed at the DNA level.

"Genetic testing for atherosclerosis may one day be widely used as an extension of the blood cholesterol count to identify those at risk at an early age, before any warning signs are present," Doctor Norum said. Such a genetic test needs to be performed only once.

The two sisters, ages 37 and 34, were first seen at Henry

Continued on page 330

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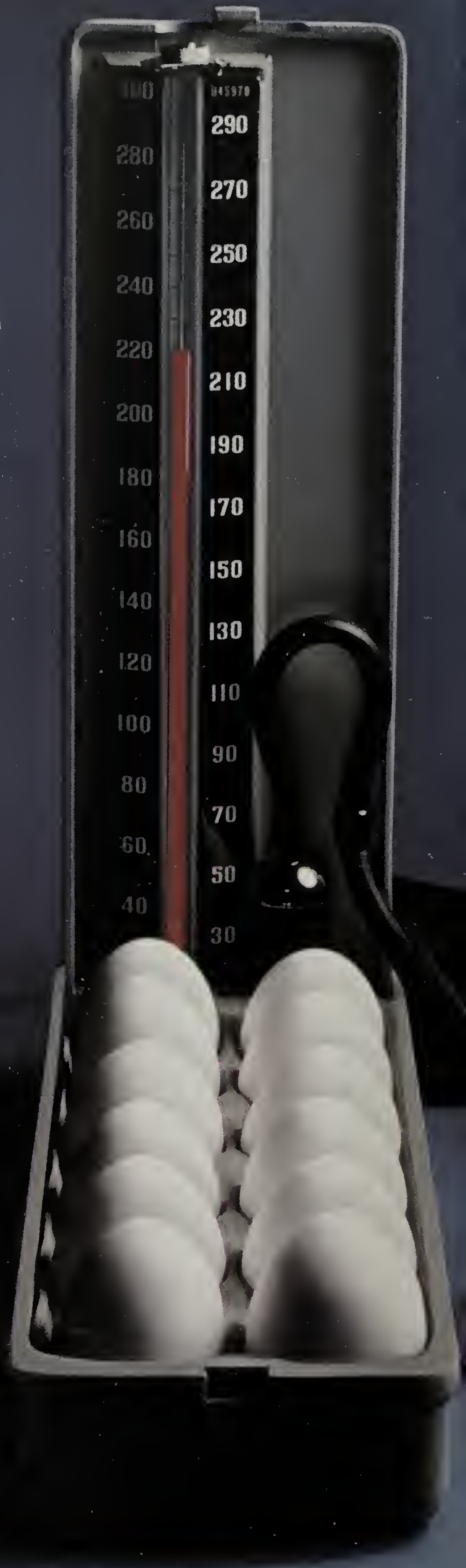
J-6138 January 1986

"High blood pressure should be a red flag to screen for cholesterol..."[1]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Wyeth Laboratories
Philadelphia, PA 19101

If your patients have hypertension, they probably have high cholesterol too.

The Framingham Heart Study[2] showed that over two thirds of the 35 and older population in that study with systolic blood pressures over 145 mmHg also had serum cholesterol levels of 225 mg/dL or more, and 46% had levels above 250 mg/dL.

While many clinical laboratories still report 250 mg/dL as "normal" cholesterol, the NIH Consensus Development Conference Statement on Cholesterol and Heart Disease[3] stated that any level above 220 mg/dL is associated with a significantly increased risk of coronary heart disease.

You need to know, because high cholesterol parallels high blood pressure as a CHD risk factor.

Epidemiological studies and large-scale prevention trials have indicated that as with blood pressure, serum cholesterol levels are proportionately related to CHD risk. Specifically, *"...for every 10 mmHg rise in pressure, there appears to be about a 30% rise in cardiovascular risk."*[4] *"...for every one percent you go up the American cholesterol scale, your subsequent rate of heart attack rises two to three percent."*[5]

And although the specific impact on CHD has not been determined, we know that many of the principal agents used to lower blood pressure actually increase cholesterol.

Wytensin® lowers blood pressure effectively without raising cholesterol.

While Wytensin is not a cholesterol-lowering agent and is not indicated for the treatment of hyperlipidemia, in controlled clinical trials[6] it caused a slight, sustained decrease in total cholesterol without reducing the HDL fraction or altering serum triglycerides.

At the same time, Wytensin lowered blood pressure as effectively as hydrochlorothiazide, propranolol, clonidine or methyldopa. Drowsiness and/or dry mouth, the most frequent side effects noted with Wytensin, usually diminish or disappear over time. In fact, in double-blind studies to date, discontinuance of therapy for all side effects occurred in about 13% of patients.

WyTensin®
(guanabenz acetate)

Antihypertensive therapy that does not increase cholesterol

See important information on following page.

References: 1. Glueck CJ: Remarks in the symposium, *Blood Pressure, Cholesterol and Coronary Heart Disease*, Washington, D.C., March 31, 1985. 2. *The Framingham Study, An epidemiological investigation of cardiovascular disease*, Section 28, U.S. Dept. of Health, Education, and Welfare. 3. National Institutes of Health Consensus Development Conference Statement, 1984: Vol 5, No 7, p 4. 4. Chobanian AV: The influence of hypertension and other hemodynamic factors in atherogenesis. *Progress in Cardiovascular Diseases, XXVI* (3): 177, Nov/Dec, 1983. 5. Castelli WP: Remarks in the symposium, *Blood Pressure, Cholesterol and Coronary Heart Disease*, Washington, D.C., March 31, 1985. 6. Data on file, Wyeth Laboratories.

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WyTensin®
(guanabenz acetate)

Antihypertensive therapy that does not increase cholesterol

Brief Summary

Before prescribing, consult the complete package circular.

Indications and Usage: Treatment of hypertension, alone or in combination with a thiazide diuretic

Contraindication: Known sensitivity to the drug.

Precautions: 1 Sedation. Causes sedation or drowsiness in a large fraction of patients When used with centrally active depressants, e g., phenothiazines, barbiturates and benzodiazepines, consider potential for additive sedative effects 2 Patients with vascular insufficiency Like other antihypertensives use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease, or severe hepatic or renal failure. 3. Rebound Sudden cessation of therapy with central alpha agonists like **Wytensin** may rarely result in "overshoot" hypertension and more commonly produces increase in serum catecholamines and subjective symptomatology

INFORMATION FOR PATIENTS. Advise patients on **Wytensin** to exercise caution when operating dangerous machinery or motor vehicles until it is determined they do not become drowsy or dizzy Warn patients that tolerance for alcohol and other CNS depressants may be diminished Advise patients not to discontinue therapy abruptly

LAB TESTS In clinical trials, no clinically significant lab test abnormalities were identified during acute or chronic therapy Tests included CBC, urinalysis, electrolytes, SGOT, bilirubin, alkaline phosphatase, uric acid, BUN, creatinine, glucose, calcium, phosphorus, total protein, and Coombs' test During long-term use there was small decrease in serum cholesterol and total triglycerides without change in high-density lipoprotein fraction In rare instances occasional nonprogressive increase in liver enzymes was observed, but no clinical evidence of hepatic disease

DRUG INTERACTIONS **Wytensin** was not demonstrated to cause drug interactions when given with other drugs, e g., digitalis, diuretics, analgesics, anxiolytics, and antiinflammatory or antiinfective agents, in clinical trials However, potential for increased sedation when given concomitantly with CNS depressants should be noted

DRUG/LAB TEST INTERACTIONS No lab test abnormalities were identified with **Wytensin** use

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. No evidence of carcinogenic potential emerged in rats during a two-year oral study with **Wytensin** at up to 9.5 mg/kg/day, i e , about 10 times maximum recommended human dose In the Salmonella microsome mutagenicity (Ames) test system, **Wytensin** at 200-500 mcg per plate or at 30-50 mcg/ml in suspension gave dose-related increases in number of mutants in one (TA 1537) of five *Salmonella typhimurium* strains with or without inclusion of rat liver microsomes No mutagenic activity was seen at doses up to those which inhibit growth in the eukaryotic microorganism, *Schizosaccharomyces pombe*, or in Chinese hamster ovary cells at doses up to those lethal to the cells in culture In another eukaryotic system, *Saccharomyces cerevisiae*, **Wytensin** produced no activity in an assay measuring induction of repairable DNA damage Reproductive studies showed a decreased pregnancy rate in rats given high oral doses (9.6 mg/kg), suggesting impairment of fertility. Fertility of treated males (9.6 mg/kg) may also have been affected, as suggested by decreased pregnancy rate of mates, even though females received drug only during last third of pregnancy

PREGNANCY Pregnancy Category C: WYTENSIN® MAY HAVE ADVERSE EFFECTS ON FETUS WHEN ADMINISTERED TO PREGNANT WOMEN A teratology study in mice indicated possible increase in skeletal abnormalities when **Wytensin** is given orally at doses 3 to 6 times maximum recommended human dose of 1.0 mg/kg These abnormalities, principally costal and vertebral, were not noted in similar studies in rats and rabbits However, increased fetal loss has been observed after oral **Wytensin** given to pregnant rats (14 mg/kg) and rabbits (20 mg/kg). Reproductive studies in rats have shown slightly decreased live-birth indices, decreased fetal survival rate, and decreased pup body weight at oral doses of 6.4 and 9.6 mg/kg There are no adequate, well-controlled studies in pregnant women **Wytensin** should be used during pregnancy only if potential benefit justifies potential risk to fetus

NURSING MOTHERS Because no information is available on **Wytensin** excretion in human milk, it should not be given to nursing mothers

PEDIATRIC USE Safety and effectiveness in children less than 12 years of age have not been demonstrated, use in this age group cannot be recommended.

Adverse Reactions: Incidence of adverse effects was ascertained from controlled clinical studies in U S and is based on data from 859 patients on **Wytensin** for up to 3 years There is some evidence that side effects are dose-related Following table shows incidence of adverse effects in at least 5% of patients in study comparing **Wytensin** to placebo, at starting dose of 8 mg b i d

Adverse Effect	Placebo (%) n = 102	**Wytensin** (%) n = 109
Dry mouth	7	28
Drowsiness or sedation	12	39
Dizziness	7	17
Weakness	7	10
Headache	6	5

In other controlled clinical trials at starting dose of 16 mg/day in 476 patients, incidence of dry mouth was slightly higher (38%) and dizziness was slightly lower (12%), but incidence of most frequent adverse effects was similar to placebo-controlled trial Although these side effects were not serious, they led to discontinuation of treatment about 15% of the time In more recent studies using an initial dose of 8 mg/day in 274 patients, incidence of drowsiness or sedation was lower, about 20% Other adverse effects reported during clinical trials but not clearly distinguishable from placebo effects and occurring with frequency of 3% or less Cardiovascular—chest pain, edema, arrhythmias, palpitations. Gastrointestinal—nausea, epigastric pain, diarrhea, vomiting, constipation, abdominal discomfort Central nervous system—anxiety, ataxia, depression, sleep disturbances. ENT disorders—nasal congestion. Eye disorders—blurring of vision Musculoskeletal—aches in extremities, muscle aches Respiratory—dyspnea Dermatologic—rash, pruritus Urogenital—urinary frequency, disturbances of sexual function Other—gynecomastia, taste disorders.

Drug Abuse and Dependence: No dependence or abuse has been reported.

Overdosage: Accidental ingestion caused hypotension, somnolence, lethargy, irritability, miosis, and bradycardia in two children aged one and three years Gastric lavage and pressor substances, fluids, and oral activated charcoal resulted in complete and uneventful recovery within 12 hours in both. Since experience with accidental overdosage is limited, suggested treatment is mainly supportive while drug is being eliminated and until patient is no longer symptomatic. Vital signs and fluid balance should be carefully monitored. Adequate airway should be maintained and, if indicated, assisted respiration instituted. No data are available on **Wytensin** dialyzability

Dosage and Administration: Individualize dosage. A starting dose of 4 mg b.i.d is recommended, whether used alone or with a thiazide diuretic. Dosage may be increased in increments of 4 to 8 mg/day every one to two weeks, depending on response Maximum dose studied has been 32 mg b.i.d., but doses this high are rarely needed

How Supplied: (guanabenz acetate) Tablets, 4 mg, bottles of 100 and 500; 8 mg and 16 mg, bottles of 100 Revised 2/14/85

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TWELVE IMPECCABLE EXCUSES FOR NOT GIVING BLOOD.

“**1.** I think I have lumbago.
2. I'm type Z negative.
3. I'm on the grapefruit diet.
4. I gave six months ago.
5. I just got back from Monaco.
6. The lines are thirteen blocks long.
7. My mother won't let me.
8. I didn't sign up.
9. I'm going out of town.
10. Asthma runs in my family.
11. I forgot to eat this morning.
12. I'm allergic to flowering magnolia.”

Each one's a doozy,
but we're hoping you
won't use any of them.
Give blood through the
American Red Cross.
Please, don't chicken out.

**EXCUSES DON'T SAVE LIVES.
BLOOD DOES.**

American
Red Cross

efore prescribing, see complete prescribing information in SK&F CO. terature or *PDR*. The following is a brief summary.

WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

ontraindications: Concomitant use with other potassium-sparing agents uch as spironolactone or amiloride. Further use in anuria, progressive enal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum otassium. Hypersensitivity to either component or other sulfonamide-erived drugs.

/arnings: Do not use potassium supplements, dietary or otherwise, nless hypokalemia develops or dietary intake of potassium is markedly npaired. If supplementary potassium is needed, potassium tablets hould not be used. Hyperkalemia can occur, and has been associated ith cardiac irregularities. It is more likely in the severely ill, with urine olume less than one liter/day, the elderly and diabetics with suspected r confirmed renal insufficiency. Periodically, serum K+ levels should be etermined If hyperkalemia develops, substitute a thiazide alone, restrict + intake. **Associated widened QRS complex or arrhythmia requires rompt additional therapy.** Thiazides cross the placental barrier and ppear in cord blood. Use in pregnancy requires weighing anticipated enefits against possible hazards, including fetal or neonatal jaundice, hrombocytopenia, other adverse reactions seen in adults. Thiazides ppear and triamterene may appear in breast milk. If their use is essential, he patient should stop nursing. Adequate information on use in children s not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or ctivation of systemic lupus erythematosus has been reported with hiazide diuretics.

recautions: The bioavailability of the hydrochlorothiazide component of Dyazide' is about 50% of the bioavailability of the single entity. heoretically, a patient transferred from the single entities of triamterene nd hydrochlorothiazide may show an increase in blood pressure or fluid etention. Similarly, it is also possible that the lesser hydrochlorothiazide ioavailability could lead to increased serum potassium levels. However, xtensive clinical experience with 'Dyazide' suggests that these conditions ave not been commonly observed in clinical practice. Angiotensin-onverting enzyme (ACE) inhibitors can elevate serum potassium; use vith caution with 'Dyazide'. Do periodic serum electrolyte determinations particularly important in patients vomiting excessively or receiving arenteral fluids, and during concurrent use with amphotericin B or orticosteroids or corticotropin [ACTH]). Periodic BUN and serum reatinine determinations should be made, especially in the elderly, iabetics or those with suspected or confirmed renal insufficiency. umulative effects of the drug may develop in patients with impaired renal unction. Thiazides should be used with caution in patients with impaired epatic function. They can precipitate coma in patients with severe liver isease. Observe regularly for possible blood dyscrasias, liver damage, ther idiosyncratic reactions. Blood dyscrasias have been reported in atients receiving triamterene, and leukopenia, thrombocytopenia, granulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when sed concurrently with hydrochlorothiazide; dosage adjustments may be ecessary. Clinically insignificant reductions in arterial responsiveness o norepinephrine have been reported. Thiazides have also been shown to ncrease the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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In Hypertension*...
When You Need to
Conserve K+

Remember the Unique
Red and White Capsule:
Your Assurance of
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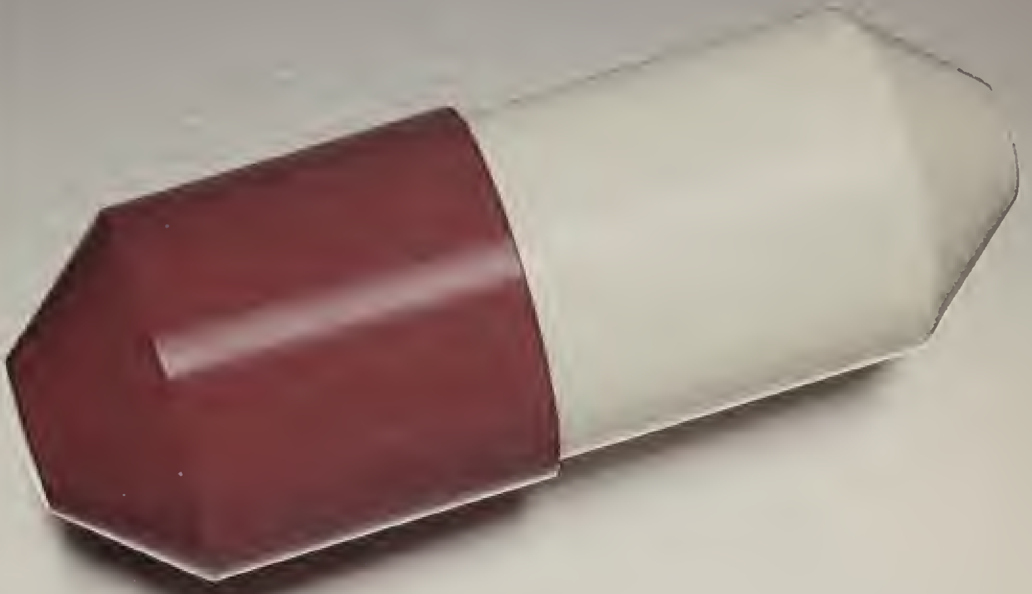
Serum K+ and BUN should be checked periodically (see Warnings and Precautions)



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Your assurance of
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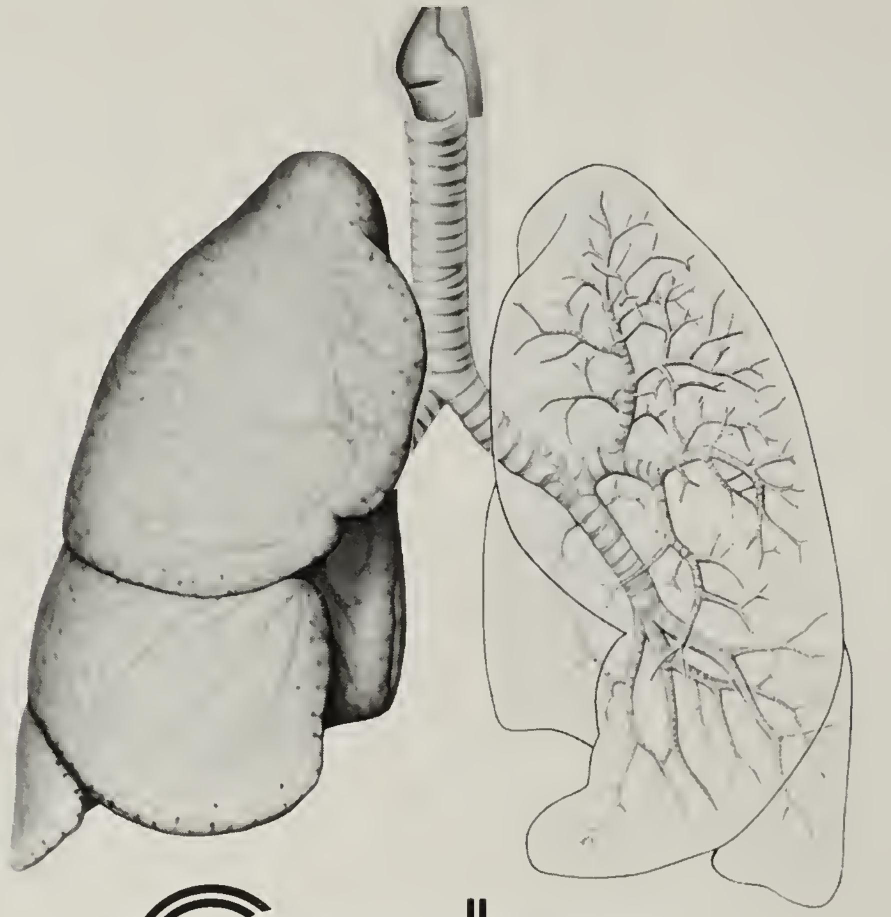
Consider the causative organisms...



Ceclor®
cefaclor

250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

Haemophilus influenzae **(ampicillin-susceptible)**, ***H influenzae*** **(ampicillin-resistant)**, ***Streptococcus pneumoniae, Streptococcus pyogenes***

Note: Ceclor® is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor® (cefaclor)

Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae, Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci).

Contraindications: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%; usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis; elevations in BUN or serum creatinine
- Positive direct Coombs' test
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly)

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MSMS wins award AMA membership

AMA President Harrison L. Rogers, Jr., MD, center, presented MSMS leaders with a plaque recognizing increased AMA membership among Michigan physicians in 1985. Richard J. McMurray, MD, right, then MSMS president, and Cathy O. Blight, MD, chairperson, MSMS Committee on Membership Recruitment and Retention, accepted the award during the February AMA National Leadership Conference in Chicago.

Progressive, in-patient treatment of anorexia and bulimia is as close as Grand Rapids.

Located on quiet, landscaped grounds, the Eating Disorders Program at Forest View Psychiatric Hospital provides top quality care for persons seeking the intimacy of a small, private psychiatric hospital. *And, it currently ranks as the only one of its kind in West Michigan.*

The program features a treatment milieu that is thorough and professional, administered by an experienced and qualified staff. Programs are available for both adolescents and adults. And admissions are processed quickly, with referrals accepted 24 hours a day.

For complete information about the Eating Disorders Program at Forest View, contact the Director of Social Services. For quality care. That's also close to home.

FOREST VIEW PSYCHIATRIC HOSPITAL

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Mass production will give you a Porsche or a Corvette.

It will not give you a Lotus Turbo Esprit.

In an industry that worships at the altar of mass production, it is hardly surprising that 99.99% of its output is produced that way.

However, what *is* surprising is the fact that eleven of those huge automated companies (churning out some 40,000 cars a day) were, at last count, getting engineering and design help from Lotus.

Lotus, on a good day, "churns" out an Esprit and a half.

It is, essentially, a hand-crafted car.

Now, why do some of the true industrial geniuses of America, Europe and Japan wend their way to our plant, tucked away in a far corner of the English countryside?

Perhaps because we offer genius of another kind.

Shockwaves at Indy.

That Lotus is made of the stuff of legends first became evident at the Indianapolis 500 in 1963 when a knee-high mini-rocket came blazing out of nowhere to change the face of racing forever.

Up against the behemoth thunder machines of that day, Lotus with its revolutionary chassis design, aerodynamic profile and extreme power-to-weight ratio came in a strong second, its first time out.

In '64 Lotus took both first and second the qualifying heats.

Then got it all together in '65. Qualifyi first, second and third. Winning first, sec and fourth.

And the mad scramble was on.

Lotus look-alikes began appearing on Grand Prix courses as fast as they could b hammered out.

Being mere copies, they performed like

And Lotus went on to burn itself into t record books at a pace unparalleled in the history of racing.

But enough perspective. Now, what is Lotus today?

It is one of the very few race cars ever to the complete transition to pure sports car.

In a World of Mass Produced Sports Cars, Stubborn Individualism.

While we at Lotus wholeheartedly embrace today's technology, we employ it to augment the hand, not replace it.

Our computer-guided milling machine assure us of critically precise engine tolerances. Computer-controlled optical scann ject components not up to our standards.

Still, the engine is unhurriedly assembled ' hand, with all parts (right down to the ılve springs) so carefully matched and balıced that it takes two full weeks to complete single engine.

Because the same care is taken in building ıe entire car, six weeks are required from round zero to its first test run.

The chassis is hand-assembled and handelded. The entire unit is then galvanized to ɔck out corrosion.

The body is of a special carbon-fiberglass ɔmposite developed by Lotus. It *can't* rust.

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The Lotus body is given nine coats of paint. ach coat is rubbed down by hand. The final ɔat is a clear coat, hand polished to give otus the most envied finish in the business.

Lotus tires are not your usual stock item.)ur engineers worked long hours with Goodear in developing a tire specifically for the urbo Esprit. One that works in total harıony with the car's weight, power and uspension system.

And now the big one. Can such a precision ıstrument take a beating?

Consider the unfortunate film director vho, not so long ago, sent a Lotus lying off a cliff in expectation of hooting a spectacular fall, folɔwed by a crashing breakup.

He got the fall and the crash. But no breakup. Not even on the econd try. Or the third.

Sledge hammers finally were brought o bear and the director got his breakup.

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A computerized fuel metering system is now also part of the power plant. It virtually *anticipates* split-second power needs. And improves gas mileage, giving the car a touring range of over 500 miles.

And to give you more of the open road while you're out there, a totally integrated, removable roof panel is now standard on every Turbo Esprit.

We also made refinements in the turbocharger, suspension, brakes and tires to keep the car in tune with its new power.

The Esprit is now as close to perfect pitch —power, precision, predictability working in unison—as a car is likely to get.

"It puts me at one with the road as no car ever has," is how one enthusiast summed it up.

He also commented on feeling secure in the car because it is very forgiving and "...always has something in reserve."

But that's another whole story....

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Lotus

Ford Hospital in 1979. Their cases were complex, involving diagnosis and treatment by several specialists.

The younger sister suffered from irregular heart rhythms and heart failure—her heart couldn't pump enough blood to meet her body's needs. Diagnostic tests showed a blockage of the coronary arteries. She was successfully treated by medication. She is currently being treated for pain caused by cholesterol blockages that have reduced blood flow in her legs.

The older sister had extensive blockages in three major blood vessels of the heart and required coronary bypass surgery. Both sisters also had clusters of yellow, fatty deposits visible on their skin. This condition was caused by their systems' inability to remove cholesterol deposits from the blood. Today, the sisters are on low-cholesterol diets, according to cardiologist Jeffrey Lakier, MD, who treated the older sister.

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"The body wasn't making excessive amounts of cholesterol," he noted. "But the amounts that were produced couldn't be removed. As a result, the fats were being deposited in the arteries and on the neck, chest, face and other areas."

Tracking down the genetic cause of the disorder involved a lot of detective work. In addition to the sisters' low HDL cholesterol levels, they had low levels of VLDL (very low density lipoprotein), particles which transport triglycerides in the blood. Blood tests of the parents and other family members also showed low levels of HDL cholesterol.

Doctors Norum, Lakier, Sidney Goldstein, head of Cardiology at Henry Ford Hospital, and eight of their colleagues reported in the *New England Journal of Medicine* in 1982 that low amounts of HDL cholesterol appear to promote atherosclerosis. Doctor Jan Breslow of Harvard University phoned Doctor Norum after reading the article and said that he had probes—bits of DNA—to identify the genes apo A-I and C-III.

Doctor Norum and his colleagues found that the two genes involved were located on chromosome 11. When the normal chromosome 11 was compared to those of the sisters, researchers found the genes apo A-I and C-III had been rearranged. This rearrangement inactivated both proteins, making them incapable of removing cholesterol deposits from the arteries.☐

Prize for advancement in child health care

Ronald McDonald Children's Charities will award $100,000 to the physician or health care professional whose work has contributed the most to the health and well-being of children.

The award will be made to the individual for the continued support of his/her program, it was announced by Gerald Newman, president of Ronald McDonald Children's Charities (RMCC), which was established in 1984 in memory of McDonald's founder Ray A. Kroc and is dedicated to supporting programs that directly benefit young people. The award will be presented in the fall of 1986 at the opening of the 100th Ronald McDonald House on Long Island.

Deadline for nominations is June 30, 1986. They should be mailed to: Gerald Newman, President, Ronald McDonald Children's Charities, McDonald's Plaza, Oak Brook, IL 60521.

"We hope this annual award will draw national attention to a dedicated individual whose pioneering work is improving the quality of life for the current generation of young people," Newman commented.

Joining with RMCC in the search for candidates are representatives from: The American Academy of Pediatrics, The American Pediatric Society, and The Society for Pediatric Research. Additional selection committee members will include three representatives plus three physician-members of the RMCC Board of Trustees.

"The Ronald McDonald House program is at the conerstone of RMCC, for the two share the common goal of helping young people live happier, healthier and more productive lives," said Newman. Families stay at Ronald McDonald Houses for a minimal fee, or at no cost, dependent on need. A major benefit of the Houses is the comfort and support families derive from sharing the burden of severe childhood illness with others undergoing the same experience.☐

Mutual Memo

2

How communications can help prevent medical liability claims

Second in a series

Doctor, Here are Four Communications Tips to Help You Prevent an Insurance Claim:

Communicate personally with your patients. Talk to patients in language they understand, with an empathetic attitude, and you'll increase their satisfaction with your care.

Give patients written information. Avoid misunderstandings. Hand out fact sheets or booklets to explain home care, office hours, emergency call procedures, and other matters.

Focus on nonverbal communication, too. Research shows that neat-appearing medical offices and courteous staffs can make patients feel more at ease, and confident in the health care you provide.

Communicate with your medical team. Clear communication with ancillary personnel and consulting specialists is essential to maintain continuity in medical treatments.

Our Attorney Seminar Helps Build Strong Defenses

How to effectively handle medical liability claims is the subject of MPMLC's annual seminar for defense attorneys. "Building an aggresive team which works for physicians is one of the seminar's primary objectives," states Fred Phelps, vice president of claims.

"Our defense seminar allows insurance professionals and lawyers to exchange new information for strengthening cases, closing them faster, and reducing costs," Phelps adds.

State Senator Alan Cropsey, sponsor of tort reform legislation, was the keynote speaker at this year's seminar. Pathologist Charles Sander, MD, told participants about placenta research which can be used to defend birth trauma cases.

You can count on MPMLC's team of defense experts.

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By Shirley Pru

Auxilians can be effective at home and in Lansing

The following article is excerpted from Mrs. Prust's inaugural address given during the May MSMS/A Annual Session in Traverse City.

Mrs. Prust, Birmingham, is new MSMS/A president.

We are going through a period of change greater than has ever occurred in our history. I would like to discuss how these changes affect our elderly, and how legislative changes impact our lives and our society, and give a few suggestions about what we can do to affect these changes in a constructive fashion.

We all know that people are living longer, that our aging population is increasing at a more rapid rate than any other segment of our society. Bringing this into perspective, in Michigan the 1980 census showed that there were 1,305,629 persons aged 60 or over living here. The Michigan Association of Health System Agencies in their long term care needs study project 60 percent of this population will have at least one service need due to disability, 27 percent will be functionally disabled. Over the next five years it is estimated that this group will increase by 3,250 individuals yearly. The state and federal governments recognize and are responding to the need with many programs such as Meals on Wheels, elder abuse programs, health screening and health education, senior nutrition programs to mention just a few. All these programs need people to make them work.

This is the best opportunity that we Auxilians have. At little cost of our time and less of money, we are able to fulfill the requirements of our bylaws which state that "our purpose shall be educational and charitable." A call to your ocal charitable agency will direct you to the areas of need: little things like a friendly visit to a home-bound senior, a weekly telephone call or an offer of transportation.

Political action

During the last few years through my auxiliary activities I have had the opportunity to speak with some of our legislators. I have learned a few things that I would like to pass on to you. First, I realized we in medicine have been very naive about the political process. Assuming that hard work and good medical care would result in legislative support was an error. Our elected officials know as much about medicine and how it functions as we do about politics.

I have come to realize that legislators have the same problems we do, they have children in college, they have expenses, they would like to remain in their positions, they are underpaid. They need financial support, they need to be exposed to our opinions through letters, phone calls and personal visits. Opening our homes to them for campaigning is another means of becoming acquainted. We should know our legislators as well as we know our neighbors.

One legislator summed it up perfectly when he said 10,000 doctors marched in Lansing last October, but where are they now? Hardly ever are they seen in the Capitol. Auxilians, this is a major error. These people pass the laws that affect all of us, they need to know our side of issues from active contact, not wishful thinking.

In conclusion, it is apparent that you as an Auxiliary member can best serve if knowledgeable about the changes occurring so rapidly. Keep informed by reading the *AMA News*, *Michigan Medicine*, *Medigram*, *Facets*, the *Auxilium* and by going to Auxiliary meetings.

With knowledge you will become a very effective salesperson not only in support of our projects but also as a recruiter of new members. Just as knowledge is strength so is increased membership. We must become aggressive, contact all physicians' spouses in every county, and attempt to enroll them. If asked, why should I become an Auxiliary member, point out the advantages of peer association, the leadership training associated with committee work and the exposure to local and state political and social activities. ☐

When someone in your family gets cancer, everyone in your family needs help.

Nobody knows better than we do how much help and understanding is needed for the family of a cancer patient. The patient's spouse is under tremendous stress, and the children are often forgotten or just plain left out. That's why our service and rehabilitation programs emphasize the whole family, not just the cancer patient.

We run local programs nationwide with millions of volunteers whose lives have been touched by family members or friends with cancer or who themselves are recovered cancer patients. That's what makes the American Cancer Society one of the largest, best motivated and most caring of any health organization in the country.

Among our regular services we provide information and guidance to patients and families, transport patients to and from treatment, supply home care items and assist patients in their return to everyday life.

Life is what concerns us. The life of cancer patients. The lives of their families. So you can see we are even more than the research organization we are so well known to be.

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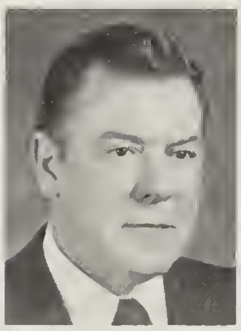
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Raouf A. Mikhail, MD, of Flint is new president of the board of directors of the American Cancer Society, Genesee County Unit. . . .**Nathan Levin, MD,**, Detroit, **Apparao Mukkamala, MD,** Flint, **I. Roderic Abbott, MD,** Flint, **Marigowda Nagaraju, MD,** Flint, **Robert Ormond, MD,** Flint, and **Margaret Setter, MD, Flint,** recently participated as faculty in a major internal medicine conference held in New Delhi, India. . . . **Gregory W. Baumann, MD,** of Jackson has been named chief medical examiner of Jackson County. He is currently an emergency room physician and chairman of the Department of Emergency Medicine at Foote Hospital. . . . **Gerhard C. Endler, MD,** Grosse Pointe Woods, and **Charles Schmitter, MD,** Ypsilanti, have been named new president and president-elect, respectively, of the Michigan Anesthesiology Society. . . .**Frank B. Walker, MD,** of Grosse Pointe Farms has been appointed to the Bylaws Commission of the American Board of Medical Specialties for the term 1986-90. He will represent the American Board of Pathology. . . .**Kenneth L. Krabbenhoft, MD** of Pleasant Ridge has been appointed to Liason Committee for Specialty Boards of the American Board of Medical Specialties for the term 1986-88. He represents the American Board of Radiology. . . .**Andres Resto Soto, MD,** of Detroit was recently awarded the Outstanding Clinical Faculty Award by the 254-member graduating class of Wayne State University Medical School. . . . **Neal E. Little, MD,** FACEP, has been named chairman of the 1986 Board Nominating Committee of the Michigan Chapter of American College of Emergency Physicians. . . .**John A. Anderson, MD,** Northville, chairman of the Department of Pediatrics and Head of the Division of Allergy and Clinical Immunology at Henry Ford Hospital in Detroit, was elected to a second term as Secretary of the American Academy of Allergy and Immunology. . . .**David Schottenfeld, MD,** will join the University of Michigan faculty as chairman of the Department of Epidemiology in the School of Public Health and will also hold the John G. Searle Professorship of Epidemiology. . . .**Donald Overy, MD,** of Pontiac was named an honorary life board member of the American Heart Association of Michigan. . . .**Robert Niven, MD,** has become a member of the Scientific Advisory Board of the Children of Alcoholics Foundation, Inc. Doctor Niven was formerly Director of the National Institute on Alcohol Abuse and Alcoholism. . . .**Emanual Tanay, MD,** Grosse Pointe, is featured in the Oscar nominated documentary *Courage to Care*. The documentary was produced in Detroit and deals with the rescue of Jews in Europe during the Nazi era.☐

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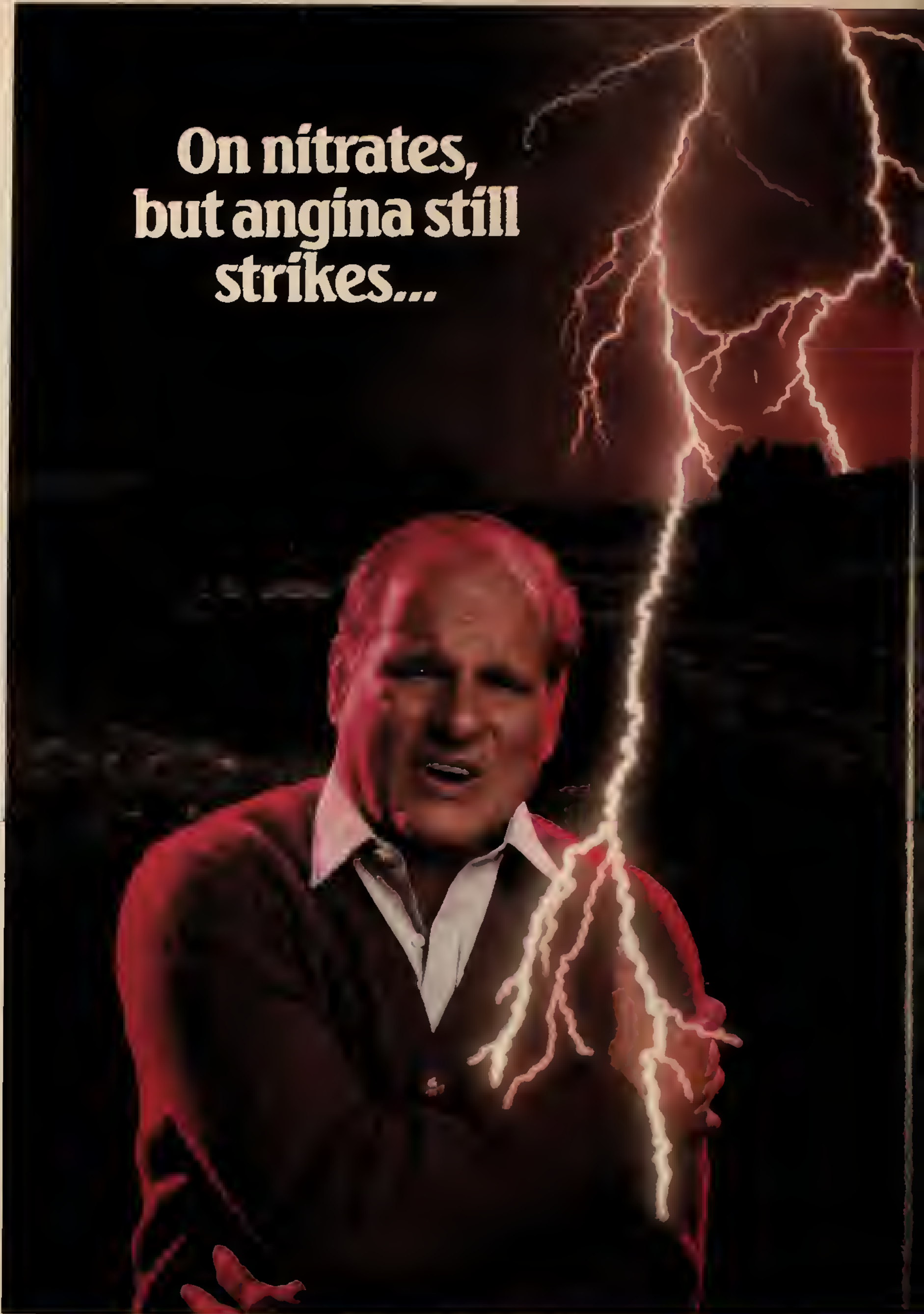
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To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin...for more comprehensive antianginal protection without side effects which may cramp an active life style.

ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page

ISOPTIN®

(verapamil HCl/Knoll)

80 mg and 120 mg scored, film-coated tablets

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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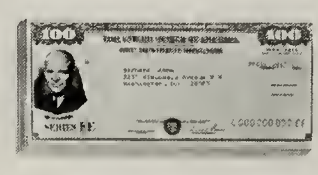

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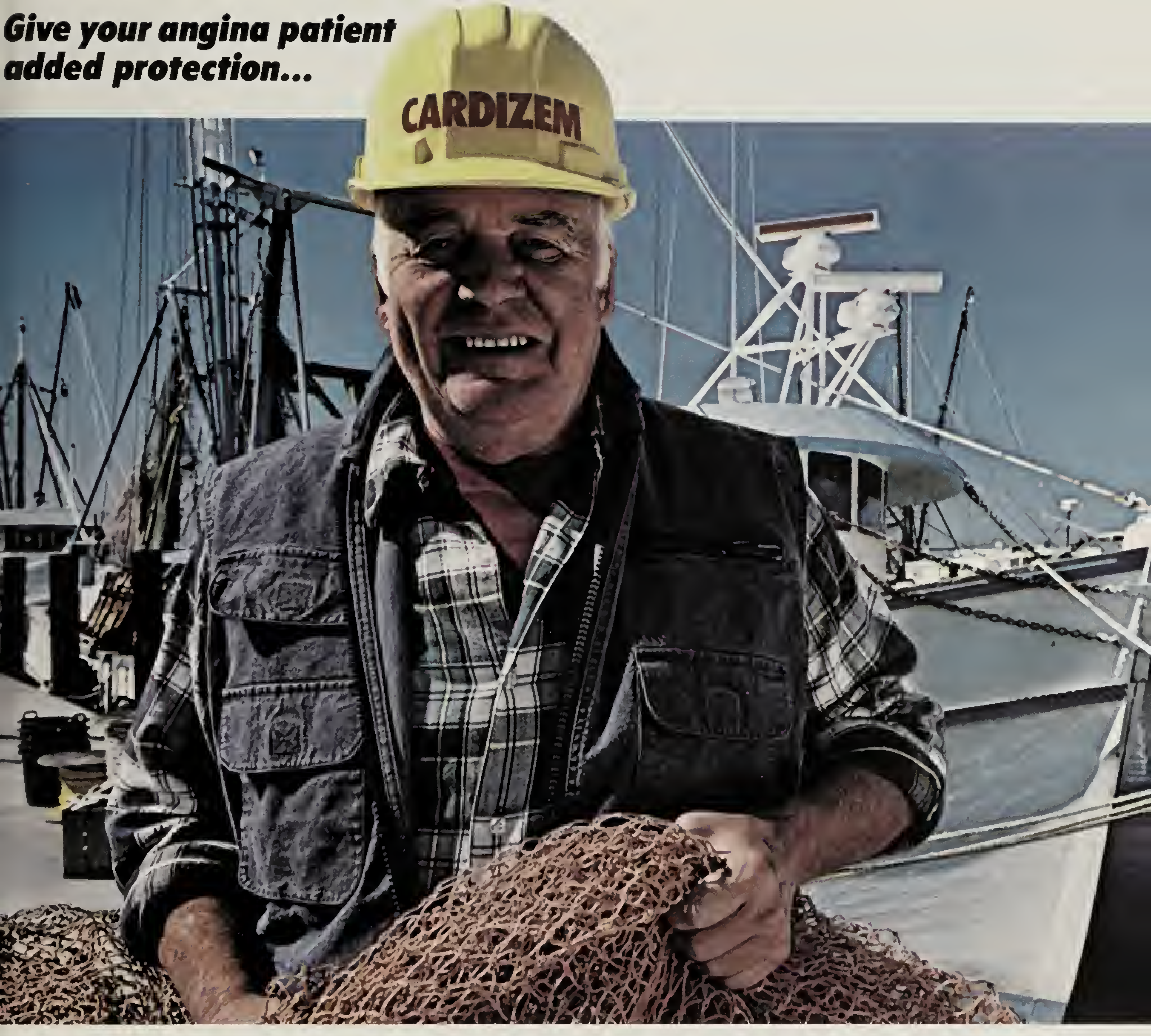

CARDIZEM® : FEWER SIDE EFFECTS
diltiazem HCl/Marion

- ***The lowest incidence of side effects among the calcium channel blockers[1]***
- ***An exceptionally safe choice for angina patients with coexisting hypertension, diabetes, asthma, or COPD[1-3]***
- ***Proven efficacy when used alone in angina[1,4-6]***
- ***Compatible with both beta-blockers and nitrates[7]***

Please see brief summary of prescribing information on the next page.

CARDIZEM® 60 mg tid or qid

diltiazem HCl/Marion

FEWER SIDE EFFECTS IN ANTIANGINAL THERAPY

BRIEF SUMMARY

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist).

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction**. CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM (diltiazem hydrochloride) in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System.	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity
Other:	Polyuria, nocturia.

The following additional experiences have been noted

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered.

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy** — CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

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See complete Professional Use Information before prescribing

0642T5

References: 1. *Physicians' Desk Reference®*, ed 39. Oradell, NJ, Medical Economics Company Inc, 1985. 2. Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): *Heart Disease: A Textbook of Cardiovascular Medicine*, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39. **3.** Schroeder JS. Calcium and beta blockers in ischemic heart disease. When to use which. *Mod Med* 1982; 50(Sept):94-116. **4.** Subramanian VB. Comparative evaluation of four calcium antagonists and propranolol with placebo in patients with chronic stable angina. *Cardiovasc Rev Rep* 1984, 5:91-104. **5.** Schroeder JS, Feldman RL, Giles TD, et al. Multiclinic controlled trial of diltiazem for Prinzmetal's angina. *Am J Med* 1982; 72:227-231. **6.** Weiner DA, McCabe CH, Cutler SS, et al: The efficacy and safety of high-dose verapamil and diltiazem in the long-term treatment of stable exertional angina. *Clin Cardiol* 1985; 7:648-653. **7.** Shapiro W. Calcium channel blockers. Actions on the heart and uses in ischemic heart disease. *Consultant* 1984; 24(Dec):150-159.

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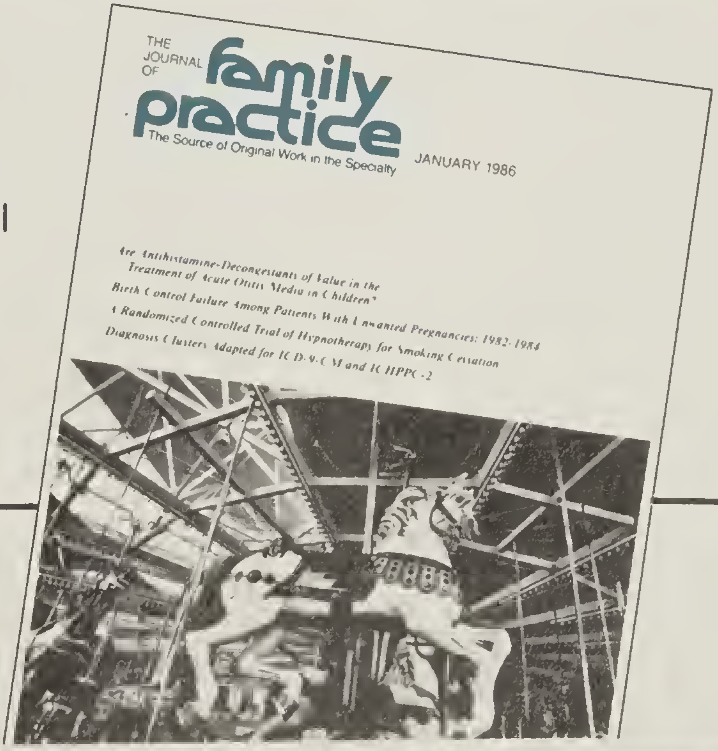

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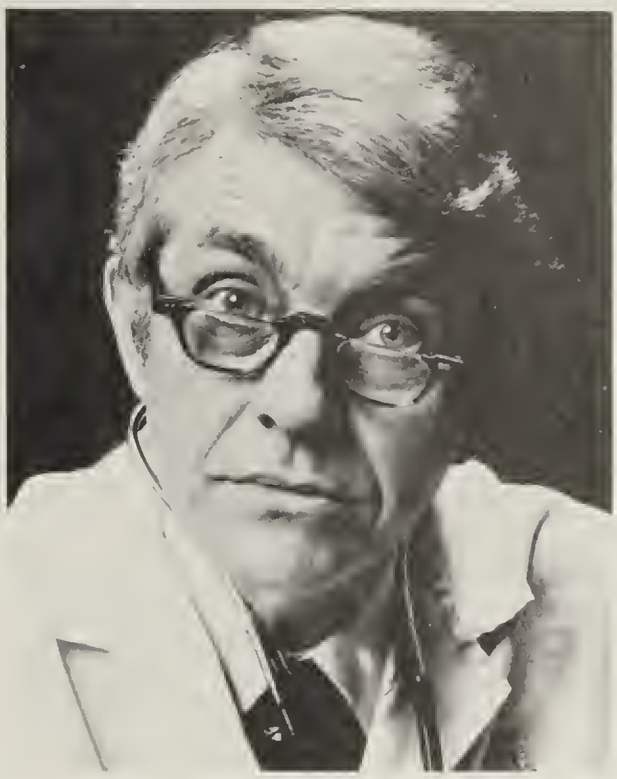

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June 15-18 — AMA Auxiliary Annual Session, Drake Hotel, Chicago, contact: Viola M. Heins, MSMS headquarters (517)337-1351.

June 27 — Practice Management Seminar: Computers in the Medical Practice, Hilton Shanty Creek, Bellaire, contact: Donna Farougi, MSMS headquarters (517)337-1351.

July 17-20 — MSMS Midsummer Board meeting, St. Clair Inn, St. Clair, contact: William Madigan (517)337-1351.

August 22 — Practice Management Seminar: Computers in the Medical Practice, Boyne Mountain, Boyne Falls, contact: Donna Farougi, MSMS headquarters (517)337-1351.

September 17 — MSMS Board Meeting, MSMS headquarters, East Lansing, contact: William Madigan (517) 337-1351.

November 19 — MSMS Board Meeting, MSMS Headquarters, East Lansing, contact: William Madigan (517) 337-1351.

OTHER MEETINGS

June 25 — Annual Business Meeting, Wayne County Medical Society, contact: Wayne County Medical Society (313)567-1640.

July 23, 12:00 noon — Council Meeting, Michigan Chapter of the American College of Surgeons, Grand Traverse Resort, contact: Viola M. Heins, executive secretary, MSMS headquarters (517) 337-1351.

July 25 — Board Meeting, Michigan Society of General Surgeons, Grand Traverse Resort, contact: Caroline Rich, MSMS headquarters (517) 337-351.

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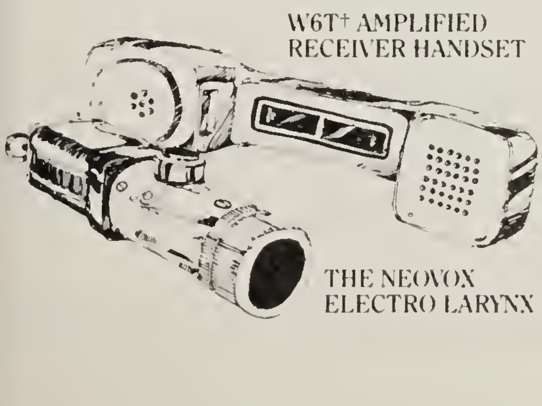

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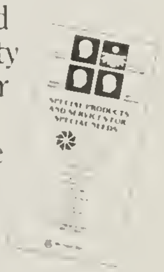

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

Date: June 20, Flexible Sigmoidoscopy. Location: Gilmore Health Education Center, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Chris Pearson, SMAHEC, 4th Floor, Stryker Center, 1521 Gull Road, Kalamazoo 49001. **Approved for:** 5.5 hours of Category I Credit.

Date: June 22-27, 22nd Annual Northern Michigan Summer Conference: An Update on Common Clinical Concerns. Location: Hilton Shanty Creek, Bellaire. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 19 hours of Category I Credit.

Date: July 24-26, Clinical Nutrition Update. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Janet Boomer, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 11.5 hours of Category I Credit.

Date: July 24-25, Coller Penberthy Thirlby Medical Conference. Location: Grand Traverse Resort, Grand Traverse Village. **Sponsor:** Munson Medical Center. **Contact:** Norma Powers, Coordinator of Medical Education, Munson Medical Center, 6th and Madison, Traverse City 49684 (616)922-9544. **Approved for:** 9 hours Category I Credit.

Date: July 26-28, Advances in the Management of Infectious Diseases. Location: Grand Hotel, Mackinac Island. **Sponsor:** University of Michigan Medical School. **Contact:** Betty Phillips, Office of Continuing Medical Education, University of Michigan Medical School, Towsley Center, Box 0201, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 10.3 hours of Category I Credit, 10.3 hours of AAFP credit.

Date: August 1-3, Tutorial on Level II Myofascial Release Technique. Location: Homestead Resort, Glen Arbor. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing (517)353-9714. **Approved for:** 24 Hours of Category I Credit.

Date: August 14-17, 18th Annual Summer Conference. Location: Grand Hotel, Mackinac Island. **Sponsor:** Michigan Ophthalomological Society. **Contact:** Jane Panin, 412 Eastland Center Professional Building, Harper Woods 48225-1084 (313)839-3011. **Approved for:** 8 hours of Category I Credit.

Date: August 17-20, Internal Medicine Update. Location: Grand Hotel, Mackinac Island. **Sponsor:** University of Michigan Medical School. **Contact:** Gayle Fox, Towsley Center, Box 0201, University of Michgian Medical School 48109-0010 (313)763-1400. **Approved for:** 11.1 hours of Category I Credit, 11.1 hours of AAFP credit.

Date: September 3, Update '86—Rehabilitation of Traumatic Brain Injury. Location: Kalamazoo, Michigan. **Sponsor:** West Michigan Physiatry, PC and Southwestern Michigan Area Health Education Center. **Cost:** $50. **Contact:** Doctor Bryan Visser, West Michigan Physiatry, PC, 252 E. Lovell Street, Suite 363E, Kalamazoo 49007. **Approved for:** 5.75 hours of Category I Credit.

Date: September 6, Basic Cardiac Life Support Course for Physicians. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Date: September 6-7, Chief Surgical Residents. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: September 7-8, Advanced Cardiac Life Support Provider Course. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School (313)763-1400. **Approved for:** 16 hours of Category I Credit.

Date: September 11-13, Grand Rapids 17th Annual International Symposium on Implant Surgery for the Hand, Upper Extremity, and Foot. Location: Blodgett Memorial Center and Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** Michigan State University College of Human Medicine and International Federation of Societies for Surgery of the Hand. **Contact:** Alfred B. Swanson, MD, Blodgett Professional Building, Suite 290, 1900 Wealthy Street, SE, Grand Rapids 49506. **Approved for:** 18 hours of Category I Credit.

Date: September 12-13, Parenteral and Enteral Nutrition 1986: Clinical Update. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: September 12-13, Hypertension 1946-1986: The First Ann Arbor International Reunion. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 481090010 (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: September 13-17, Tutorial on Level I Muscle Energy Technique. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: September 25-27, November 13-15, Neonatal/Infant/Child Life Support. Location: Gilmore Health Education Center, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association and Southwestern Michigan Area Health Education Center. **Contact:** William H. Scott, MD, Southwestern Michigan Perinatal Association, 252 E. Lovell Street, Kalamazoo 49007 (313)383-6469. **Approved for:** 19 hours of Category I Credit.

Date: September 25-27, Diagnostic Ultrasound. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 15 hours of Category I Credit.

Date: September 26-28, American Academy of Pediatrics, Michigan Chapter 37th Annual Scientific Meeting. Location: Hilton Shanty Creek Summit Conference Center, Bellaire. **Sponsor:** Michigan Chapter, American Academy of Pediatrics. **Contact:** Mr. P. Miles Tiernan, 32245 Hearthstone, Farmington Hills 48018. **Approved for:** 7 hours of Category I Credit.

Date: September 26-28, Tutorial on Level I Myofascial Release Technique. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 24 hours of Category I Credit.

Date: September 29-October 1, Hemodynamic Monitoring and Management Seminar. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 14 hours of Category I Credit.

Date: October 1-3, Mechanical Ventilatory Support and Management. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical

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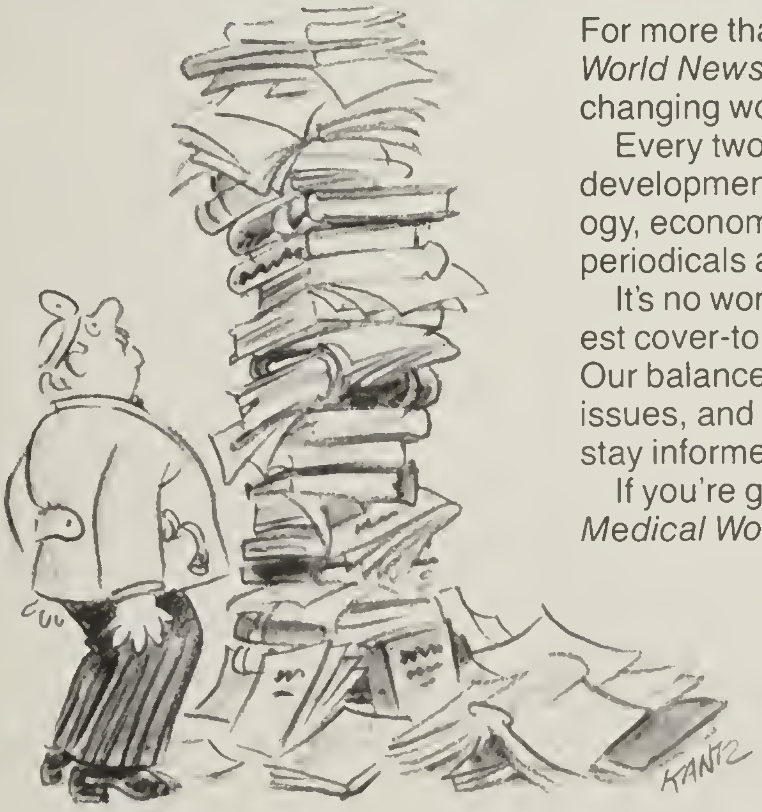

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School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 15 hours of Category I Credit.

Date: October 2-3, Diabetes Care. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 16 hours of Category I Credit.

Date: October 4-5, National Conference for Chief Medical Residents. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313) 763-1400. **Approved for:** 10 hours of Category I Credit.

Date: October 9-10, Ear, Nose and Throat Practicum. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Jolene Glaspie, Towsley Center, Box 0201, University of Michgian Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 17.25 hours of Category I Credit, 17.0 hours of AAFP credit.

Date: October 9-10, Ins and Outs of Critical Care: Fluids, Nutrition and Renal Management. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010, (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: October 11-15, Tutorial on Level II Manual Medicine Techniques (Above Diaphragm). Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: October 16-17, Perinatology and Neonatology. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Janet Boomer, Towsley Center, Box 0201, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 13.25 hours of Category I Credit.

Date: October 16-18, Common Surgical Problems in Childhood. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 18 hours of Category I Credit.

Date: October 19-23, Tutorial on Level II Craniosacral Techniques. Location: Kellogg Center, MSU. **Sponsors:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: October 20-21, Care of the Elderly. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-0010. **Approved for:** 12 hours of Category I Credit.

Date: October 24-25, Advances in Multidisciplinary Approaches In the Treatment of Cancer of the Breast, Head and Neck, and Ovaries. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 10.5 hours of Category I Credit.

Date: October 24, Basic Cardiac Life Support Course for Physicians. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 6 hours of Category I Credit.

Date: October 25, Advanced Cardiac Life Support Course Recertification. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 8 hours of Category I Credit.

Date: October 27-29, Impairment Evaluation and Disability Considerations: Medical and Legal Perspectives. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 17 hours of Category I Credit.

Date: October 30-November 2, Chest Radiology: Pioneers and New Frontiers. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 14 hours of Category I Credit.

Date: November 7, 1986, Advanced Cardiac Life Support. Location: Mercy Hospital, Muskegon. **Sponsor:** Mercy Hospital. **Contact:** Sue Franklin, Box 358, 1500 E. Sherman Blvd., Muskegon, MI 49443 (616) 7252506. **Approved for:** 8 hours of Category I Credit.

Date: November 7, Basic Cardiac Life Support Course for Physicians. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 6 hours of Category I Credit.

Date: November 7-9, Tutorial on Manual Medicine Techniques Applied to the Extremities. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 24 hours of Category I Credit.

Date: November 8-9, Advanced Cardiac Life Support Provider Course. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 16 hours of Category I Credit.

Date: November 12-14, Real-Time Ultrasound in Obstetrics and Gynecology. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 21 hours of Category I Credit.

Date: November 13-15, Neonatal/Infant/Child Life Support. Location: Gilmore Health Education Center, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association and Southwestern Michigan Area Health Education Center. **Contact:** William H. Scott, MD, Southwestern Michigan Perinatal Association, 252 E. Lovell Street, Kalamazoo 49007 (313)383-6469. **Approved for:** 19 hours of Category I Credit.

Date: November 17-18, Laser Medicine and Surgery: The Aerodigestive Tract. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 17 hours of Category I Credit.

Date: November 19-21, Laser Medicine and Surgery: Specialty Applications. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 22.5 hours of Category I Credit.

Date: December 15-19, Principles of Manual Medicine. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine, College of Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

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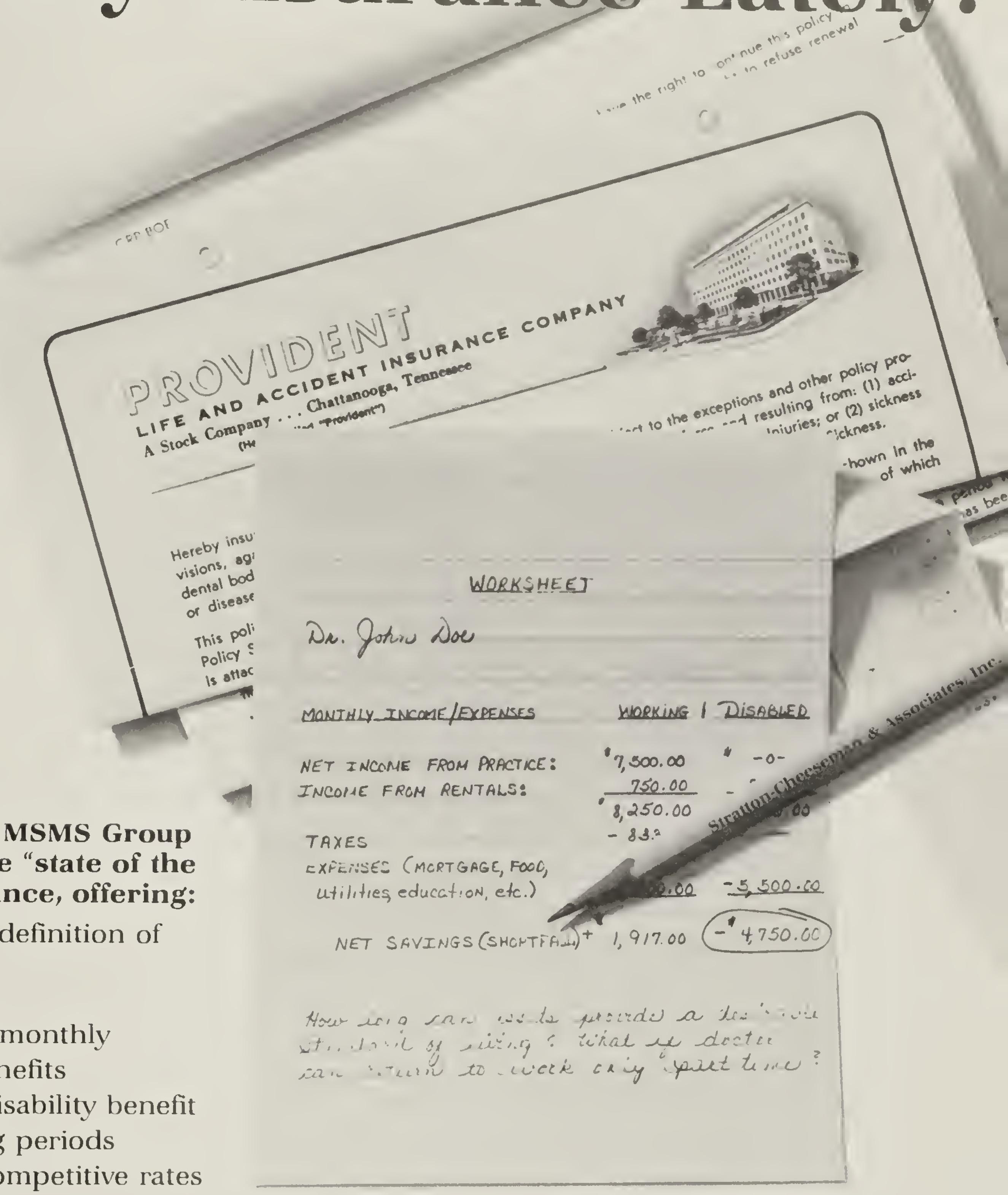

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Anthony Abruzzo, MD
Plymouth
Doctor Abruzzo died April 20 at the age of 75. He received his medical degree from Loyola University School of Medicine in 1936. He served as president of the Lapeer County Medical Society in the late 60s. He practiced and was an administrator in the field of psychiatry.

Helen S. Barnard, MD
Muskegon
Doctor Barnard, a long time Muskegon physician, died April 4 at the age of 88. She received her MD degree from University of Michigan School of Medicine in 1925. In 1985 Doctor Barnard became a member of the non-profit relief agency International Aid which studied economic suffering of Poland.

Howard Benjamin, MD
Marco Island, Florida
Doctor Benjamin, formerly of Kent County, died March 20. He graduated from Northwestern Medical School in 1936 and served in the Army Medical Corps during World War II. Doctor Benjamin was a member of the Kent County Medical Society since 1946 and served as its president in 1958. He retired in 1980.

Volney N. Butler, MD
Dearborn
Doctor Butler died March 11 at the age of 87. He graduated in 1921 from Wayne State University School of Medicine. He practiced for 50 years in Detroit and served as senior surgeon at Highland Park General Hospital before retiring in 1973.

Robert A. Byberg, MD
Bloomfield Hills
Doctor Byberg, former chief of surgery and vice-chief of staff at Beaumont Hospital, Royal Oak, died March 25 at the age of 70. He graduated from Wayne State University Medical School in 1943 and served in the Army Medical Corps for 4 years. Doctor Byberg maintained a general surgical practice in Royal Oak for 31 years before retiring in 1984.

Herbert H. Cohen, MD
Detroit
Doctor Cohen, a retired Southfield eye, ear, nose and throat specialist, died April 10 at the age of 76. He volunteered for Army service in World War II and was stationed in the Philippines. He graduated in 1935 from Wayne State University School of Medicine. Doctor Cohen was a staff member at Sinai Hospital until his retirement in 1975.

Ronald E. Easterling, MD
Flint
Doctor Easterling, 53, of Flint Township, died March 24. He was a 1957 graduate of University of Michigan Medical School. He served in the Army from 1957-63. Doctor Easterling was director of renal dialysis and transplant services at Hurley Medical Center and was director of nephrologic education at McLaren General Hospital.

Charles H. O'Donnell, MD
Farmington Hills
Doctor O'Donnell, of Farmington Hills, died March 16 at the age of 71. He graduated from Jefferson Medical College, Philadelphia, in 1939. He spent his career practicing trauma surgery at Ferndale Clinic and teaching at Wayne State University. He retired in 1981.

Robert J. Polack, MD
Boyne City
Doctor Polack, a Burns Clinic physician, died April 13 at age 64. He served in the Army from 1943-45. He was a 1947 graduate of Washington University Medical School, St. Louis, Missouri. Doctor Polack was chief of staff of the Primary Care Unit at Burns Clinic.

Clarence M. Schrier, MD
Kalamazoo
Doctor Schrier, of Kalamazoo, died March 23 at the age of 77. He graduated from University of Michigan Medical School in 1934. He served as president of the Southwestern Michigan Psychiatric Society in 1956 and held a life membership in the Kalamazoo Academy of Medicine and Michigan State Medical Society.

Benjamin R. Van Zwalenberg, MD
Grand Rapids
Doctor Van Zwalenberg, of Grand Rapids, died April 17 at age 73. He graduated in 1937 from the University of Michiigan Medical School and served in the Army Medical Corps during World War II. Doctor Van Zwalenberg was active in the American College of Radiology and was a former president of the Michigan Radiological Society. He maintained his practice in Grand Rapids until his retirement in 1978.

Jay R. Venema, MD
Mesa, Arizona
Doctor Venema, former chief of Internal Medicine at Butterworth Hospital, Grand Rapids, died April 20 at the age of 77. He received his medical degree from University of Chicago in 1935, and did postgraduate work in Internal Medicine at Butterworth Hospital and Henry Ford Hospital. Doctor Venema retired in 1975.

The rate for each classified advertisement in *Michigan Medicine* is 40¢ per word, with a minimum charge of $20.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

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Continued on next page

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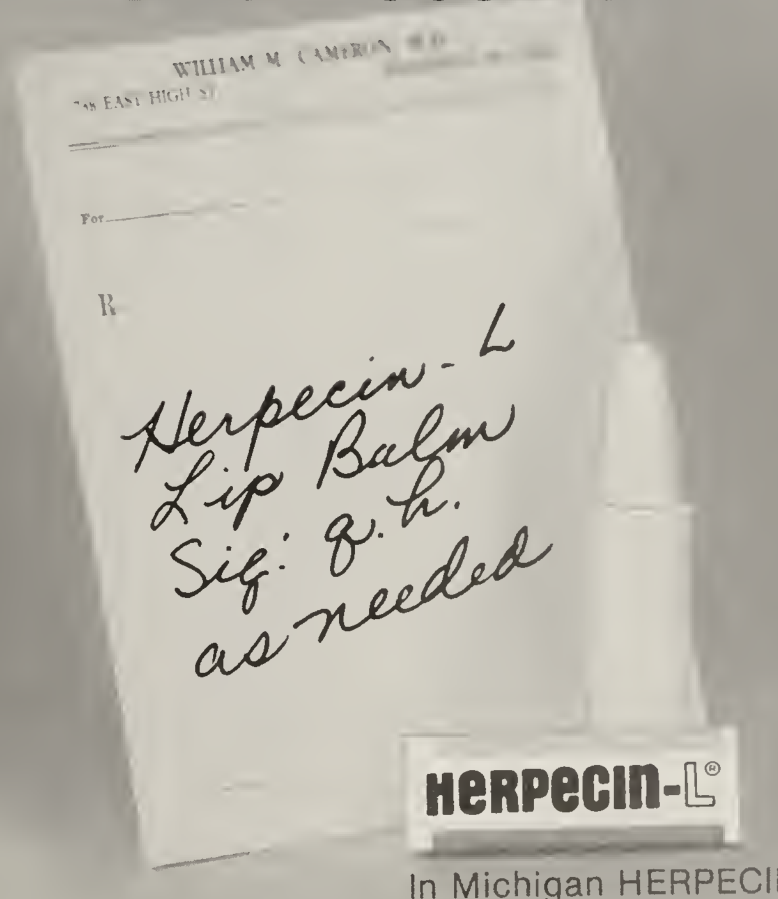

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By Thomas R. Berglund, MD

This has gotten personal!

"This has gotten personal!!" a young pediatrician told me in the hospital corridor. He was referring to the malpractice crisis. The crisis became personal when Medical Protective notified him that they would not be renewing his insurance policy. I guess it is our nature as physicians that we don't want to get involved with the legislative process or politics until it touches us personally.

By the time you read this page the legislature will have enacted a "tort reform" package and it will have been signed into law by the Governor. The set of bills is a compromise — it is not totally what the Michigan State Medical Society worked to pass. The statute of limitations is not what we wanted and the "cap" is a "cosmetic" cap. But, the legislature *did* pass much of what we wanted and worked for. Time will tell if it has a beneficial effect on liability insurance availability and cost.

Physicians are used to taking care of acute episodic events: set and cast the fracture: prescribe penicillin for the "strep" throat, and remove the acute appendix or diseased organ. Unfortunately, the legislative process is not that simple. Physicians also are used to being in command in the hospital or their offices. Doctors do not suggest, they *order*. In the state legislature, the representatives and senators are *not* our patients and we do *not* order them. They have many constituencies and we are only one of them, even though many of us believe that we are the most important.

All-consuming issues

During the past three years, and especially this year, professional liability and tort reform have been all-consuming issues with both MSMS staff and leadership. MSMS President-elect Carl G. Gagliardi, MD, Board chairman last year, was the right person at the right time. He spent countless hours in Lansing, away from his practice and family, working on our behalf and he accomplished much. He should receive thanks from all of us. Instead, he is being criticized by some who do not fully understand the legislative package. Neither Carl nor MSMS "sold out." It was the legislature that made a "deal."

Most of you, I'm sure, are sick of hearing me ask you to get involved, but I'm doing it again. We do not have the end result tort reform that we want or need. We must continue our efforts. Rather than dropping your membership, critizing the leadership or forming splinter groups, get behind MSMS as we renew our efforts to find a solution to the professional liability problem.

During my years of involvement the legislature has dealt with many other medical issues besides "tort reform" and it will continue to do so. If we are to be successful we must get and *stay* involved. We cannot hide behind the excuses of "I'm too busy" or "politics is dirty."

This is an election year. Laws are developed by legislators who are elected by the people. The only way to get a silk purse out of a sow's ear is to start with a silk sow. Get involved and send some "silk" legislators to Lansing. Don't forget, "This has gotten personal!!"☐

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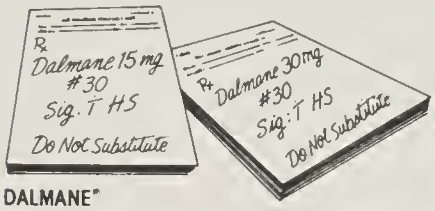

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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e g*, excitement, stimulation and hyperactivity.

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MICHIGAN MEDICINE

July 1986 AWARD-WINNING JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 85, No. 7

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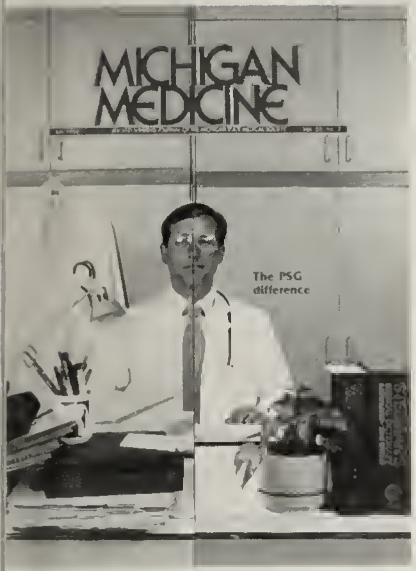

About the cover: While we may have exaggerated, many physicians have experienced dramatic improvements in their practices with Physician Service Group's help.
Photo by Kim Kauffman

n next month's issue of *Michigan Medicine*: The end of Round I and the beginnings of Round II in the professional iability ring will be the subject of our August Special Report.

Special Report

360 Physician Service Group, Inc. (PSG), an MSMS subsidiary, offers members a variety of services designed to enhance their practices. Among the services it offers are debt collection, practice management consultations and seminars, a credit card program, administrative services and much, much more. This Special Report offers samples from PSG's extensive menu. One article will walk you through an actual practice management consultation, and others will introduce you to the staff and expertise available: Sheri Greenhoe; Leland E. Holly II, MD; Judy Marr

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By Leland E. Holly, II, MD

Risk management, quality assurance or defect control

Holly

By whatever name, it's the same and it can never be 100 percent. But it can be a whole lot better!

No matter what the endeavor, whether it's building automobiles or producing health care, the time to get the defects is *before* the product goes to market.

- It's cost effective.
- It's image building.
- It makes you feel good.

The goals are:

- Behavior modification
- Product design improvement
- An effective monitoring/correction system

The tools are:

- Education
- Rewards
- Penalties
- Research and testing
- Customer feedback integration
- Personnel feedback integration
- Product (outcome) evaluation/analysis

Easy? No! Do-able? Yes.

Inexpensive? No! Will it control costs? Yes.

Can it be done in a day? No. A couple of years? Maybe.

Is it good for medicine? Yes.

Is it good for consumers? Yes.

Will it reduce malpractice? Yes.

Will it be 100 percent? No, of course not.

Let's go for it!

I'd like to think you and I had done the best we could do.☐

Doctor Holly, Muskegon radiologist, is MSMS treasurer, and a member of the Committee on Publications.

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Prominent figures help kick off Eye Care Project in Michigan

Michigan Governor James Blanchard, left, and nationally-known news commentator Paul Harvey, right, helped the Michigan Ophthalmological Society kick off the National Eye Care Project in Michigan. Michigan Project Coordinator Floyd S. Tukel, MD, invited the two to join a news conference held May 2 in Dearborn to describe the purposes of the project. Governor Blanchard and Harvey were in the vicinity to address a meeting of the Adcrafters Club that day. Governor Blanchard complimented the ophthalmologists on the project, which aims to bring eye care to the elderly who have no physicians, whether they can pay fees or not. Harvey promised to cover the project on a future radio show. The National Eye Care Project, an activity of the American Academy of Ophthalmology, can be reached through the toll-free number shown in the photo.

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PROJECT
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SPECIAL REPORT

By Leland E. Holly, II, MD

A membership benefit: Think PSG!

MSMS, is a highly respected and active organization of 11,000 physicians. It has the strength, experience, talent and opportunity to provide individual members and allied professional groups quality financial, administrative, advisory, educational and purchasing benefits not ordinarily readily and reasonably available to them. Many of these benefits already are available at modest cost to MSMS members through the Physician Service Group, Inc. (PSG), an MSMS subsidiary.

We need MSMS physicians and allied groups to *think PSG*!

A valuable resource

Think PSG whenever your concerns turn to: financial planning; estate planning; practice management/office procedure; billing/insurance problems; stagnant practice/marketing/style of practice; major practice purchases; cutbacks with associates, HMOs, hospitals, etc.; joint ventures; staffing and continuity in our professional organization; the future for medicine and your own practice; education of office employees; enhancement of practice efficiency and success; closing your practice.

Some of the help you will receive will be through inexpensive, regularly offered seminars. Some will be through endorsed programs like credit card and collection services. Many statewide organizations already purchase administrative services which include operational staffing all the way up to convention planning.

Some help will be a simple offer of assistance in making good decisions about office computerization. Some may be only referral to recognized sources.

PSG recognizes that its interests are often in highly competitive areas and has made the decision to endorse only services which are available to all Michigan physicians, and which are of good value and high quality. Many wheels have been designed and built, but PSG has felt often that they are not round enough, are too narrow or are built insuffiently well to satisfy physicians travelling on the sometimes peculiar Michigan practice pathway.

A PSG penchant has been to address the future, particularly the role of computers in practice management, and the impact of the rapidly changing social environment of medical practice. The two are not entirely unrelated.

There is a role for PSG here and its pursuit of solutions is a driving force. PSG perceives that MSMS members practice in an increasingly unfriendly environment where helpful friends are needed. PSG aspires to be a friend.

Think PSG! When you have a concern, call and talk it over with John Richards (517) 337-1351. For that, there is no charge and it may save you big dollars! ☐

Doctor Holly is president of the PSG Board of Directors.

John Richards, general manager of MSMS subsidiary operations, has big plans fo Physician Service Group.

"I think that PSG is going to become increasingly important to MSMS as an organization, and to the physicians it services. The environment for physicians has become highly competetive, and many doctors are looking for services and products which will help them survive much of the economic turmoil that is going on."

In order to meet this challenge, Physicians Service Group soon will offer an expanded and more sophisticate menu of "survival tools" to its physician clients. The popular practice management seminars for example, will be more closely targeted to specific physician groups: solo practitioners will find courses designed to solve their particular needs, and group practice members will be offered courses especially suited to them.

All physicians—solo and group members—will be affected by the new federal tax laws, and PSG is gearing up to offer seminars on the laws' impact on practice and personal finances. "I think we'll

By Sheri W. Greenhoe,
Managing Editor

Physician Service Group shops for practice products and services

ok back on this change in
x law as having revolution-
ied the way physicians rule
eir financial world," Richards
id. And while doctors will
obably consult several
urces on this complex topic,
physicians look at Physicians
ervice Group as a neutral par-
," Richards said. "And that's
e kind of seminars we
esent—we do not sell prod-
ts."

"Stockbrokers, CPAs, and
ancial planners are
arketing certain types of
oducts—and rightly so—and
ey are going to push physi-
ans in a certain direction,"
chards continued. "The role
PSG is to be neutral on
ese products and to simply
plain to physicians their best
ossible strategies."

Neutrality is carefully
uarded in the criteria PSG
ses to choose its course
resenters: Individuals must
gree not to sell products to
he audience. Attorneys, CPAs
nd bankers, among others,
ave spoken at practice
anagement seminars, "all of
hom are extremely anxious to
resent these programs,"
ichards said. "Given that the
udience is made up of physi-
ians, they readily agree to
end their top people."

John Richards, standing, is general manager of MSMS subsidiary operations. With him, from left to right are Donna Veara, secretary, and Viola Heins and Caroline Rich, account executives.

Personalized consultations

While seminars for physicians and medical office staff members address a variety of topics, including personnel, financial control, collection, computerization and retirement, they are designed mainly to introduce physicians to concepts and systems.

"Physicians who are interested in a more individualized program can arrange for a practice management consultation," said Richards. (See related article on page 363.) "We have practice management consultants who will go to a physician's office on a fee-for-service basis, study that individual's situation, then make recommendations."

Typically, physicians look to Physician Service Group for help with cash flow and financial problems. "A physician will begin to realize that his or her practice gross is falling off, or that there are severe cash

Continued on next page

flow problems," Richards said. "Our practice management consultants will go out there and begin to identify specific problems—collection, billing systems, personnel. Generally it is a combination of all those things."

PSG's major advantage to MSMS members is that it acts as a "shopping service" which sorts goods and services for physicians who don't have time to "shop" for themselves. "Physicians may wish to look to their medical society, which has the time and energy to select the best products for the price," Richards said.

A physician shopping for a computer, for example, is inundated with myriad hardware options and software programs. "By pulling in experts from the field, PSG can do a lot of the work physicians normally would have to do," Richards said.

Another item on PSG's "shopping" list is debt collection. "We are aware of a lot of collection services, some of which are every bit as good as the one that we endorse," Richards said, "but the one we endorse happens to meet our criteria. I.C. System is statewide, meaning it serves every physician in the state, even those accounts other agencies would find unprofitable. It is obligated to accept them in order to maintain MSMS endorsement." (See related article on page 365.)

"One of the things we always insist on is that an endorsed product or service be available to all our members. I think that is a very valuable service, and it is a very valuable edge that physicians will come to appreciate about using products and services endorsed by Michigan State Medical Society."

Contacts, too

New physicians setting out on their own, or established physicians thinking about entering into a contract, both will find that PSG has valuabl contacts. Competent legal an financial expertise is just a phone call away. Even if you don't find your particular nee mentioned here, call PSG—its staff probably knows where you can find help.

Other services in the planning stage include a "gold card" credit card program which will provide physicians with a substantial line of credit; a pre-paid legal plan, recognizing that most physicians will require fundamental legal assistance sometime during their career; a discount magazine subscription service, and computer software development.

"PSG understands that physicians at different phases in their careers—from residency through retirement—have different needs, and require different products and services."☐

Physician Service Group, Inc., is overseen by a board of directors chaired by Leland H. Holly, II, MD, at the end of the table, above. Other board members pictured are Frederick Bryant, MD, center, Elizabeth Hutchinson, MD, next to Viola Heins, staff member, and Mark G. Campbell, MD. Board members not pictured include Bruce Drukker, MD; Allen Turcke, MD, and Bruce Ambrose, MSMS executive director.

By Judy Marr, Editor

Anatomy of a practice consultation

Westshore Family Medicine, PC, had some business problems.

"Over the previous few years we had identified various problems, mostly with our finances," said Joel Jarvis, MD, one of three partners in the firm. The other two are James oswell, MD, and Michael anka, MD.

"We felt we were working hard, and wondered why we weren't realizing the income from our practice we thought we ought to.

"We thought perhaps our overhead was too high. We also felt a computer might be helpful, but we didn't know how to assess that possibility or where to purchase one. We needed assistance."

The Muskegon family practice turned to the Physician Service Group, Inc. (PSG), the MSMS subsidiary which provides practice management consultations for physicians.

"We knew of PSG, having read of it through *Michigan Medicine* and *Medigram*, and had it in the backs of our minds for some time," said Doctor Jarvis.

"We knew MSMS, that it was going to care more about us. After all, it's our society. And if MSMS didn't do a good job, we'd complain," he added, with a glint in his eye.

Consultants John Anthony and Fred Jirous came to the group's aid. Jirous met with the physicians in the practice and with their office manager to describe the consultation process. He established rapport with the manager, who then was able to prepare the office staff.

On two typical practice days in March, Jirous conducted his survey. He assessed the physical structure, a pleasant new wood and brick building near Muskegon Mercy Hospital.

He looked at the reception rooms from the patient's point of view, interviewed the office staff and each of the partners, checked the books and the patient scheduling systems.

"Normally we do an A to Z survey," said Anthony, who estimated he and Jirous have conducted 200 practice management surveys collectively in the several years they've been in the business for MSMS.

"Our overall goal is to help the doctors keep their operational costs as low as possible to provide them more net income. The whole key is efficiency.

The PSG consultants examine:

1) Appointment scheduling, to determine whether people are seen on time, whether there is equal access to the practice for new and old patients, how long it takes to schedule an examination for patients presenting with mild to acute symptoms.

2) Medical records, to see whether they are complete and would stand up to a medical/legal review, and how

they are filed.

3) The accounting system and financial flow, to determine whether the physicians can determine what portions of income are derived from hospital inpatients, office patients, laboratory work, testing, etc.

4) Cash management, and whether there is too much sitting in idle, non-interest-bearing accounts.

5) Billings and insurance forms, to determine whether

Continued on next page

they are consistent and timely.

"We think physicians should have written policies on mailing out statements, on Medicare and Medicaid participation. Then the staff can follow the policies correctly and there's no guessing game each month," said Anthony.

6) Patient flow, to assure the patients get into the examining room quickly and are prepared in good time, and that ancillary persons function as the physicians wish.

Improvements

Anthony and Jirous pointed out many things Westshore Family Medicine could improve. Among them:

1) High traffic areas of the office building were wearing out.

2) The office personnel could reflect a more professional look by wearing lab coats and name tags.

3) Continued emphasis was needed on a friendly staff attitude toward patients.

4) The practice needed to institute a schedule for regular employee meetings.

"One thing the consultants thought was really deleterious to our management was that we were still on a manual, pegboard system for records," said Doctor Jarvis. "We were using a lot of time searching for ledger cards. Additionally, they pointed out a problem with accounts receivable. We couldn't age them easily with the manual system."

For the latter two reasons, Westshore partners decided to look into a computer system.

"To us, the problem was mind-boggling, however. We just didn't have the time to research it," said Doctor Jarvis.

Basically Anthony and Jirous agreed with what the Westshore partners thought they needed, Jarvis said.

"But they went further, and looked at our practice, at what we needed, and could afford. They suggested a way to computerize that would really help us."

Westshore is purchasing an on-line, real-time hookup with a Southfield computer service. Office personnnel are excitedly anticipating the arrival of their computer hardware, and are planning a gradual transition.

"We are not going to change everything at once, just put our accounts on the computer," Jarvis reported.

Not all doctors have problems with financial management, Anthony pointed out. "Some have problems of not enough patients.

"Most doctors have plenty of patients. But nearly all would like to see a different mix of patients. That's difficult to achieve, but we work on it."

For those physicians, the PSG consultants analyze patient retention, image-building, new patient generation and patient satisfaction.

"We look at gaps in appointment scheduling, whether the doctor needs to see more of some kinds of patients, or a different kind of patient. We try to segment the market and see what the doctor's objectives are."

Generally physicians receive their consultations in friendly fashion, report Anthony and Jirous.

"Don't forget," says Anthony, "they've asked us to come, and they are paying fo our services. We make it clea we are there to come up with some answers."

The two consultants try to work as delicately and unobtrusively as possible with office staff, they said.

"We found them helpful, professional, anticipatory, not overbearing," said Doctor Jarvis. "They did what they said they would do and didn't spend extra time kibitzing. Yo can't ask for anything better."

Reporting back

The Anthony/Jirous modus operandi is to have an evenin meeting with all the physician in the practice at the conclusion of the consultation.

The consultants deliver a written report if requested, an give a three-hour oral description of their findings and recommendations.

"We often suggest the physicians tape record our conversation so they can refer back to it," said Anthony. "We don't hold back much. We're being paid to be outspoken, after all."

Westshore Family Medicine i implementing the changes suggested by Anthony and Jirous, and looks to the future for a full evaluation of the results.

"It's up to us to do the work they suggested," said Jarvis. "We have to understand things aren't going to be different just because they were here. Finding out about the problems, and getting advice about them don't make the changes happen. Even after we make the changes we have to wait for their effects."

Doctor Jarvis does feel, however, that the consultants did a good job.

"I think it was really worthwhile," he said. "They have been helpful to us."☐

DOCTOR
IS
IN
ENGLEMAN

"Judging by past experience a two o'clock appointment means I don't have to get here till 3:30. . . !"

By Sheri W. Greenhoe,
Managing Editor

Collection service and credit card program trim receivables

Physician Service Group offers two more services—debt collection and credit card payment—that can save you money.

Collection service

Between July 1, 1985 and March 31, 1986, the PSG-endorsed collection agency etrieved $1,739,202 in eceivables for Michigan MDs. Not bad, considering most of he accounts they pursued were more than a year old!

I.C. System, Inc., based in St. Paul, Minnesota, has been servicing associations for 35 years. (Association-endorsed work makes up 98 percent of ts business, which resulted in $75 million in collections last year.) MSMS, one of 47 state medical societies offering I.C. System, has endorsed the service since 1979. John Richards, general manager of MSMS subsidiary operations, was attracted by the fact that professional collection is available to every member of MSMS through "The System."

"We work with clients that other agencies wouldn't touch," said Thomas A. Stenklyft, Director of Association Relations for I.C. System. Accounts that others would deem "undesirable" include those with especially high or old debt, or those in a remote location. To maintain its MSMS endorsement, though, I.C. System is obligated to accept every past due and legally collectable account over $20. Debts may consist of any delinquent account—including bad checks, balance after insurance benefits, notes, contracts and even judgments. Physicians also may submit debtors' accounts owing any of his or her business interests and/or personal accounts.

Twelve veteran field representatives service Michigan clients under the direction of Dal Ferris, regional manager.

Another aspect that impressed PSG is that I.C. System does regular and "negative" reporting. That means they report on accounts they have collected, as well as on those they have not. Another advantage: physicians have the option of having payments sent directly to them and not through I.C. System.

Collection representatives employ techniques "as professional as you are" to persuade debtors to pay. All contacts are made by phone or by mail, and they comply with state and federal laws prohibiting harassment, Stenklyft said. Physicians who sign up with "The System" by paying a one-time retainer fee are authorized to use the I.C. System name in pre-collection contacts. And, clients are protected under a unique hold harmless/indemnification agreement which is backed by a $250,000 errors and omissions insurance policy.

"It's my feeling that I.C. System would be hard to improve upon," Richards said.

"I've recorded all the receivables in this book, Doctor Miller. Would you care to review them?"

Credit card program

"Another collection device we have is the merchant credit card program," Richards continued. "It has a very competitive discount rate."

That program enables patients to pay at the time of service with either MasterCard or VISA. "Several office managers have told me that patients with past due bills are happy to put their balance on a credit

Continued on next page

card," said Sue Esch, coordinator for the MSMS/PSG credit card program.

In addition to regular office calls, patients can charge prescriptions and even major surgery through the program, she said.

Esch currently maintains 450 computerized physician accounts at a discount rate of only 3.5 percent. (Banks are now charging about seven percent.) She acts as liaison with the bank, relieving physicians' staff from most detail work, hence saving practice costs.

Sometimes she takes her service a step further: "Occasionally a slip will come through without an authorization number," said Esch, "so I will call the toll-free number and take care of it. It saves the doctors' staff time and it saves us a 22-cent stamp!"

"I have really worked hard to make customer service the biggest advantage to our program," she stressed. "I've gotten to know many of our clients quite well over the phone—we have good working relationships."

Physicians who participate in the credit card program pay a one-time $50 fee, which covers the cost of an imprinter, an office sign or sticker, forms and instructions. (Additional forms are available to physicians at no charge for the duration of their contract with PSG's credit card program.) A one dollar service charge is assessed for each semi-monthly check sent to the physician's office.

Large physician groups including HMOs, as well as small solo practices are among Esch's clients. "We process charges from two dollars up to $2,000 and more," she said. The average ticket is for about $40.

Contact Sue Esch at (517)337-1351 for further information about I.C. System or the credit card program.☐

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CARRY THE CARING CARD.

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of Michigan

By Sheri W. Greenhoe,
Managing Editor

Associations can hire PSG's administrative services

How can a medical specialty group pull off an annual meeting as efficiently as a larger, heavily-funded association? How can it maintain complicated membership records with no staff, no computer and no office space?

With PSG's administrative services, meetings, mailings and membership recordkeeping are no problem for such organizations.

"We offer administrative services to ten different groups—most of them medical specialty organizations—which need professional, high quality services, but do not have enough revenue to hire a person full-time," said John Richards, general manager of MSMS subsidiary operations. "We employ first-rate people who work for each specialty society on a part-time basis."

"It's true," said Caroline Rich, a PSG account executive. "We don't work for *one* boss, we work for *many* bosses." Rich, who has been with PSG for nine years, and Viola Heins, who has been with PSG for eight, handle five accounts apiece. Between them they handle a variety of services for the Michigan Society of Anesthesiologists; the Michigan Society of Internal Medicine; the Michigan Society of General Surgeons; the Michigan Society for Respiratory Care; the Michigan Society of Medical Assistants; the Michigan State Medical Society Auxiliary; the Michigan Association for Medical Education; the Michigan Society of Pathologists; the Michigan Chapter of the American College of Surgeons, and the Michigan Section of the American College of Obstetricians and Gynecologists.

Rich and Heins are classified as "executive director" or "executive secretary" by these groups.

PSG negotiates an individualized annual contract with each group which reflects specific services required. Among the available services are membership application and mailing list processing; mailings; dues billing and collection; membership ledger and file maintenance, and follow-through on mail and telephone requests.

More services

Other optional services include meeting preparation, registration, name tag and handout preparation, minute-keeping, duplication and distribution and related clerical services. Some groups contract for newsletter preparation, accounting services and national-level liaison. All clients have use of PSG and MSMS storage and meeting facilities.

"Having us here on a part-time basis is so much less expensive than hiring a full-time staff, leasing an office, buying equipment," said Heins. "Not to mention the expense of paying benefits," she added.

"The most valuable thing we offer is continuity," said Rich, referring to the annual change of leadership groups typically experience. As a "staff" member she can help to smooth the transition. "Our clients build up trust in us, and we develop trust in them—it's a two-way street," Rich added.

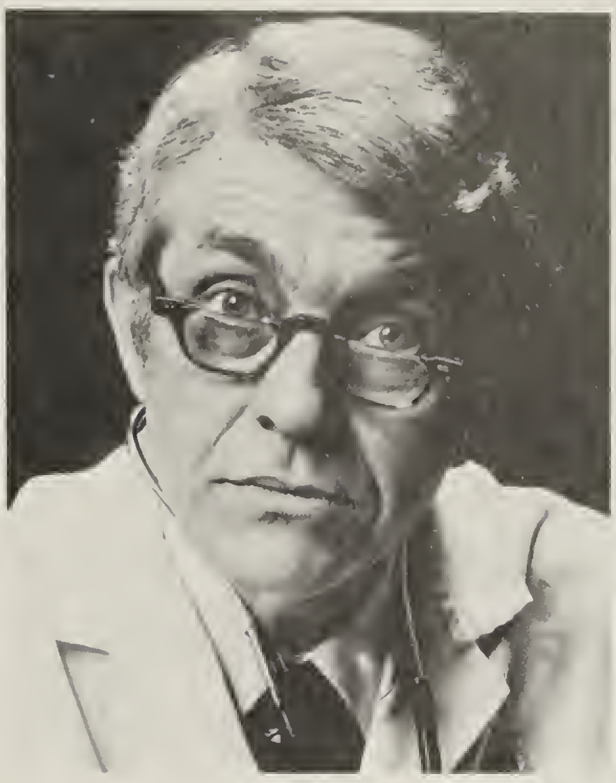
PSG account executives Caroline R and Viola Heins compare notes.

Is it for us?

Groups thinking about contracting for PSG's administrative services should consider their needs: Does the size of our group require outside services? Is it fair and appropriate to expect current office staff to handle these duties? Is our membership application/retention process handled smoothly now? How much money are we willing to spend to streamline things? Do we have an adequate volunteer pool from which to draw?

Interested groups may call PSG to explore the practicality of hiring its services. "We came within 50 hours of the actual amount of work required in estimates for our clients last year," Rich said.

"This," Heins added, "is *our* specialty."☐



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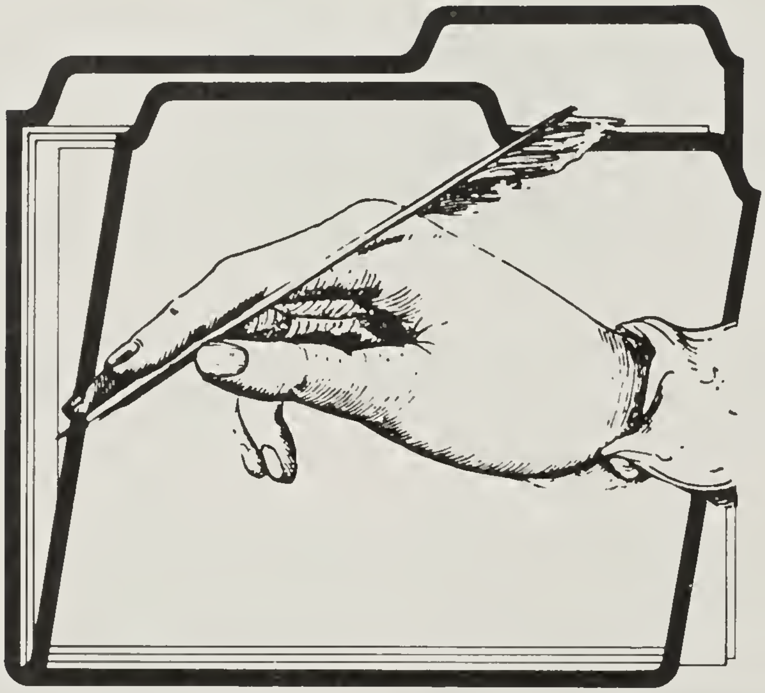
Amicus Curiae brief filed for MSMS in Supreme Court case



This brief was filed May 30, 1986 on behalf of MSMS by legal counsel Richard D. Weber of Kerr, Russell and Weber, Detroit. It focuses on the scope and interpretation of certain provisions of the Medical Malpractice Arbitration Act.

Statement of issues presented

I. DOES THE PARTY SEEKING TO AVOID A MEDICAL MALPRACTICE ARBITRATION AGREEMENT BEAR THE BURDEN OF PROVING AN INVALID AGREEMENT?

The Trial Court answered, "Yes."

The Court of Appeals answered, "Yes."

Amicus Curiae contends the response should be "Yes."

II. IS AN UNBORN CHILD BOUND BY AN ARBITRATION AGREEMENT SIGNED ON ITS BEHALF BY A PARENT?

The Trial Court answered, "Yes."

The Court of Appeals answered, "Yes."

Amicus Curiae contends the response should be, "Yes."

McKinstry v. *Valley Obstetrics-Gynecology Clinic, PC* Supreme Court Case No. 77531

AMICUS CURIAE BRIEF OF MICHIGAN STATE MEDICAL SOCIETY

STATEMENT OF FACTS

Amicus Curiae incorporates the Statement of Facts set forth in the Briefs of Appellees Valley Obstetrics-Gynecology Clinic, PC and Saginaw General Hospital.

ARGUMENT

I. Introduction

INTEREST OF MICHIGAN STATE MEDICAL SOCIETY

The issues presented to this Court in this action focus on the scope and interpretation of certain provisions of the Medical Malpractice Arbitration Act (MMAA). MCL 600.5040; MSA 27A.5040, *et seq*. Specifically, this Court is asked to determine whether a party who seeks to avoid a medical malpractice arbitration agreement which is in conformity with MMAA requirements bears the burden of proving that the agreement is invalid. This Court is also faced with the question of whether a parent binds her unborn child to arbitration when she signs an arbitration agreement on behalf of the child.

Michigan State Medical Society (MSMS) has a significant interest in the outcome of these issues. MSMS represents the professional interests of over 10,000 licensed physicians in the State of Michigan. The vast majority of these physicians are staff members at various health care facilities which promote and engage in the daily use of arbitration agreements. These health care facilities include hospitals, clinics, health maintenance organizations and a variety of other medical practices which, pursuant to the guidelines of the MMAA, frequently enter into arbitration agreements with their patients. In most every instance, the arbitration agreement between the health care facility and the patient also binds the individual health care provider to arbitration. MCL 600.5042(5); MSA 27A.5042(5); *Kukowski* v *Piskin*, 415 Mich 31, 35-40 (1982).

MSMS contends that the Michigan Legislature, through he enactment of the MMAA, provided patients who agrees o arbitrate medical malprac- ice disputes with significant due process protections which assure that the patients are ully informed of their waiver of a jury trial. The form of the arbitration agreements used in his case, like the arbitration agreements commonly used by health care providers throughout Michigan, are in conformity with the MMAA statutory equirements. These agreements, therefore, inform the patient that (1) the waiver of a rial by jury is voluntary, 2) the signing of the agreement is not prerequisite to receiving health care or treatment and (3) the agreement to arbitrate may be subsequently revoked within 60 days after execution, or, in the case of hospital treatment, within 60 days after discharge from the hospital.

It is undisputed in this case that the signed arbitration agreements at issue contained all of the statutory requirements and protections. MSMS believes, therefore, that the burden of proving that the arbitration agreements were not a valid waiver by Appellants of their right to a jury trial must rest with Appellants who seek to subsequently vitiate the agreements. The factual findings by the trial court, affirmed by the court of appeals, demonstrate that Appellants are unable to show that they were coerced, fraudulently induced or otherwise uninformed when Mrs. McKinstry signed the arbitration agreement on behalf of herself and her unborn child.

Amicus Curiae further asserts that the court of appeals correctly recognized that is was the Legislature's intent to allow a parent to bind not only a "minor child" to arbitration under the MMAA, but also an unborn child. Any other interpretation of the MMAA would effectively eliminate from arbitration those medical malpractice claims, like the claim in this case, involving birth trauma.

The MMAA was enacted for the remedial purpose of responding to a medical malpractice crisis which today is more alarming than ever. Nowhere is this crisis more acute that in the area of birth trauma or the so-called "bad baby" cases. Exorbitant insurance premiums, litigation risks and jury verdicts have caused a substantial number of OB-GYN physicians in this state to completely eliminate child delivery from their practices. It is common knowledge that in many counties there are no physicians willing to deliver children. Health care costs associated with pregnancy and child delivery have escalated dramatically.

The MMAA was aimed at reducing these serious problems. If the Legislature's purpose and intent is to continue to be effectuated, then an exception can not be carved out for the unborn child. The court of appeals'' decision, therefore, should be affirmed.

II. The party seeking to avoid a medical malpractice arbitration agreement bears the burden of proving the agreement is invalid.

This state has long recognized that there is a strong public policy in favor of arbitration as an efficient and expeditious means of resolving disputes without necessitating resort to the court system. *Kukowski* v *Piskin*, 415 Mich 31, 33 (1982); *Detroit Automobile Inter-Insurance Exchange* v *Reck*, 90 Mich App 286, 289-290 (1979); *Miller* v *Swanson*, 95 Mich App 36, 40 (1980). Legislation promulgated to promote the use of arbitration, like the MMAA, is given liberal construction in order to effectuate its purpose. *Swanson*, *supra*; *Ewald* v *Pontiac General Hospital*, 121 Mich App 793, 797 (1982). Doubts concerning the arbitrability of an issue are generally resolved in favor of arbitration. *Reck*, *supra*.

The MMAA provides, in pertinent part, that a patient "may, if offered, execute an agreement to arbitrate a dispute, controversy, or issue arising out of health care or treatment by a health care provider . . . ," MCL 600.5041(1); MSA 27A.5041(1), or by a hospital, MCL 600.5043(1); MSA 27A.5043(1). A patient signing an arbitration agreement with a health care provider may further revoke the arbitration agreement entirely within 60 days after execution, MCL 600.5041(3); MSA 27A.5041(3), or, in the case of a hospital, within 60 days after discharge from the hospital, MCL 600.5042(3); MSA 27A.5042(3). Under this provision, these options must be expressly stated in the arbitration agreement. The arbitration agreement must further expressly provide in 12-point boldface type immediately above the space for the parties'' signatures that the "agreement to arbitrate is not a prerequisite to health care or treatment. . . ." MCL 600.5041(5); MSA 27A.5041(5). Additionally, all arbitration agreements must be accompanied by an informational brochure which details the terms of the arbitration agreement and the revocation provision. MCL 600.5041(6); MSA 27A.5041(6).

Because these statutory requirements assure that patients are expressly informed of their

Continued on next page

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voluntary waiver of the right to a trial by jury when signing the arbitration agreement, safeguarded with the patient's right to subsequently revoke the agreement, there is a statutory presumption that a conforming arbitration agreement, once signed, is valid. MCL 600.5041(7); *Morris* v *Metriyakool*, 418 Mich 423, 438-439 (1984); *Harte* v *Sinai Hospital of Detroit*, 144 Mich App 659, 653 (1985). These statutory requirements provide patients with enough information so that they can make an informed decision on whether to elect arbitration and waive their right to a jury trial. *Morris, supra*.

When a conforming arbitration agreement is signed by both parties, the majority of Michigan courts, including the appellate court in this action, have placed the burden on the party seeking to subsequently avoid the agreement to prove a valid basis for rescinding or invalidating the agreement. *Morris, supra* at 437-442; *Kunath* v *Sinai Hospital of Detroit*, 149 Mich App 32 (1986); *Cushman* v *Frankel*, 111 Mich App 604 (1981); *Brown* v *Siang*, 107 Mich App 78 (1981); *Capman* v *Harper-Grace Hospital*, 96 Mich App 510 (1980): *Contra; Moore* v *Fragatos*, 116 Mich App 179 (1982); *Roberts* v *McNamara-Warren Community Hospital*, 138 Mich App 691 (1984). In writing the lead opinion of this Court's decision in *Morris*, Justice Kavanagh held that the express statutory requirements of the MMAA afford significant protections to patients and health care providers who enter into arbitration agreements. Accordingly, Justice Kavanagh opined that the burden of proving that a conforming agreement is subsequently invalid should be borne by the party seeking avoidance.

We reject plaintiffs' allocation of the burden of proof to defendants. The burden of avoiding these arbitration agreements, as with other contracts, rests with those who would avoid them. The act stated that an agreement to arbitrate which includes the statutory provision shall be presumed valid. MCL 600.5041(7), 600.542(8); MSA 27A.5041(7), 27A.5042(8). The burden of showing some ground for rescinding or invalidating a contract is not altered merely because the contact entails eschewal of constitutional rights. Plaintiff's allegation of coercion, like other contract defenses of mistake, duress, and fraud, must be proven by the party seeking to avoid the contact on such grounds. *Id* at 439-440.

The burden of proving an alleged constitutional violation rests on the party asserting it. *Brown* v *Siang, supra*. If the statute can be construed in a manner consistent with the constitution, then the party alleging unconstitutionality has failed to meet that burden. *Siang, supra*; *Dearborn Twp* v *Dearborn Twp Clerk*, 334 Mich 673 (1952).

In this action, the court of appeals, consistent with the majority position, conclude that the burden is on Appellants to show facts which would justify avoidance of the arbitration agreements.

We find without merit, however, plaintiffs' claim that because the agreement fails to provide a more detailed statement of the procedures used in arbitration pursuant of the MMAA, and an explanation of how they differ from those of a trial, there can be no knowing, intelligent and voluntary waiver of a patient's constitutional right to trial. Although plaintiffs' argument is consistent with positions recently espoused by

Continued on page 378

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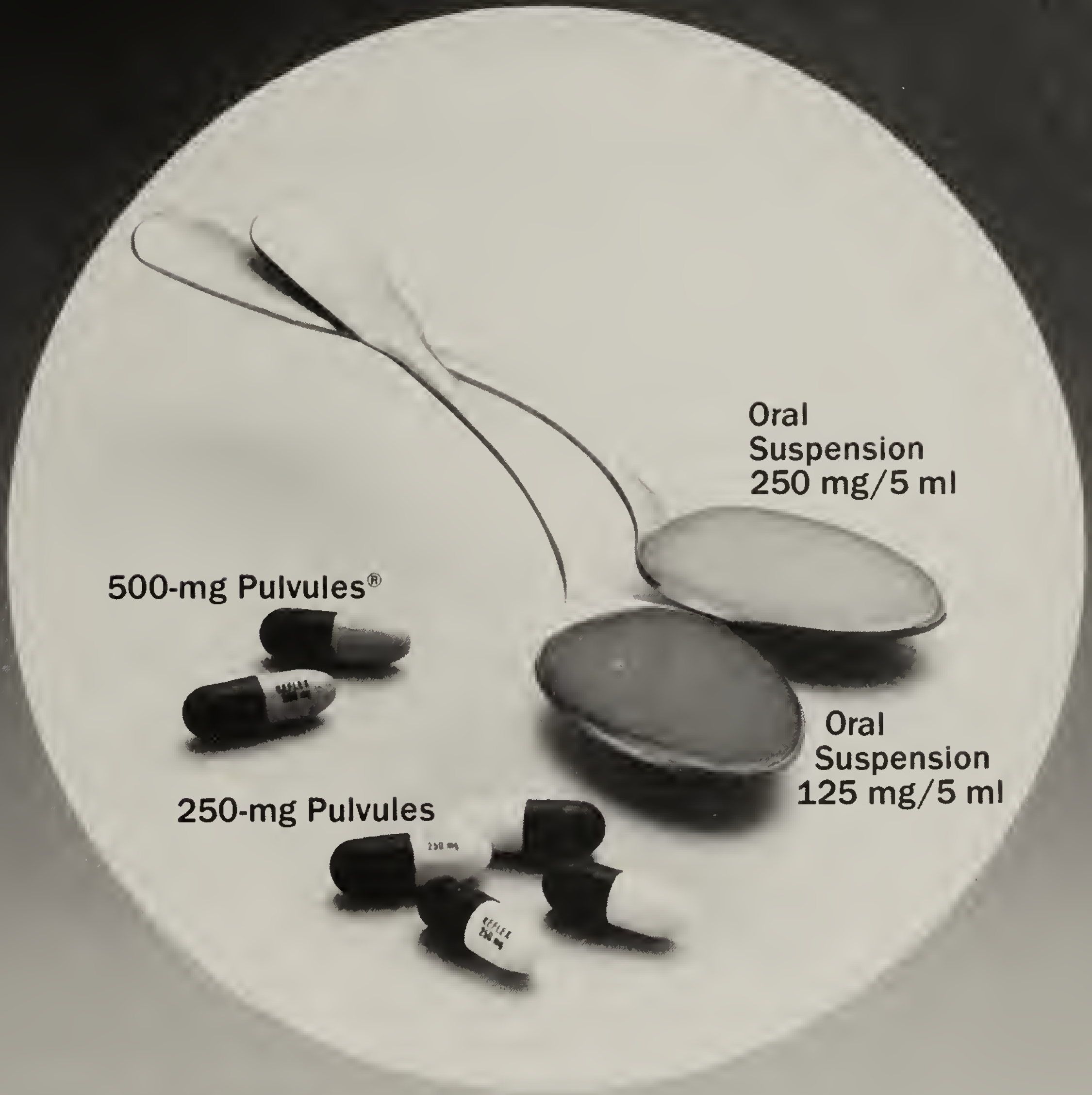
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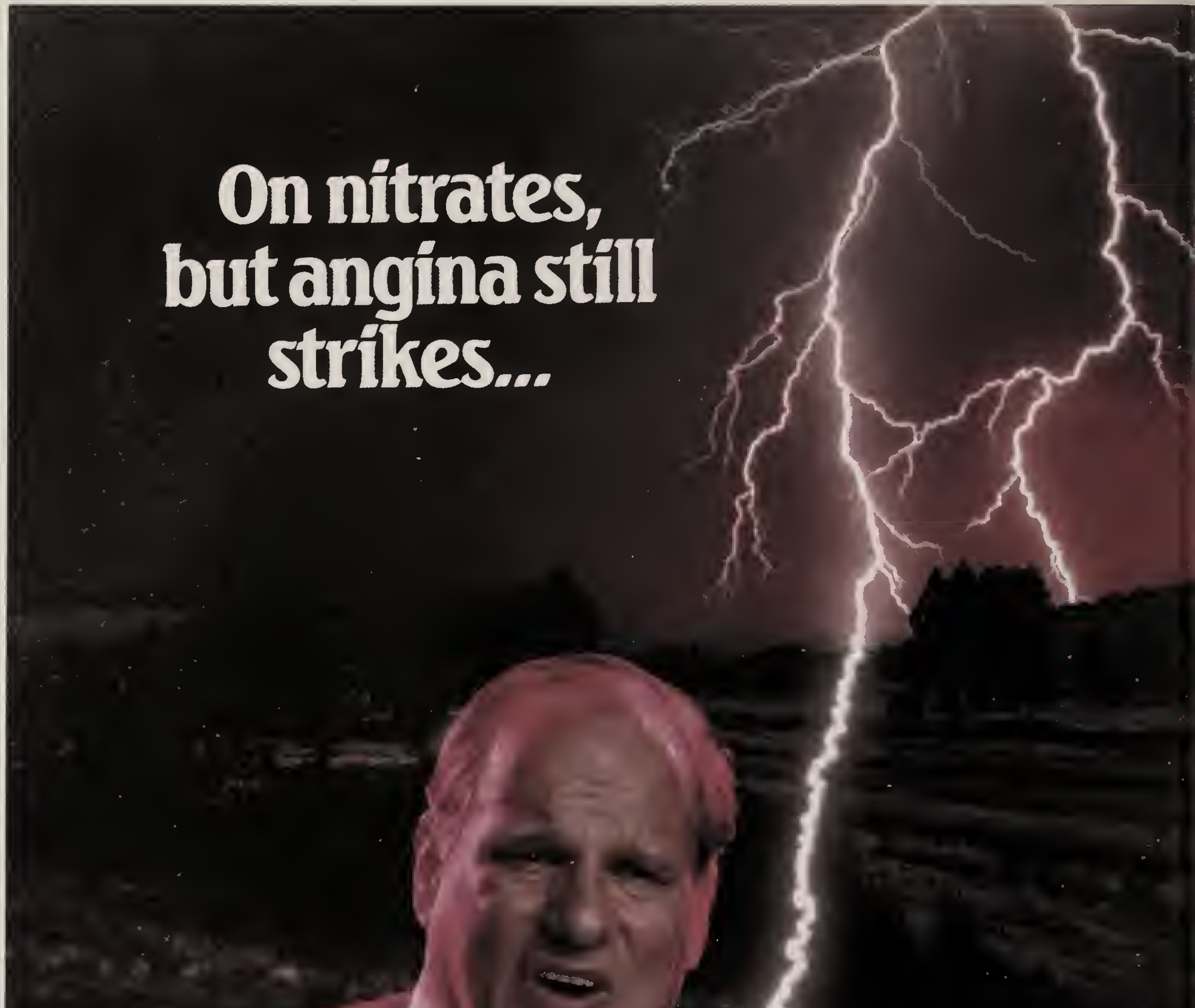
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Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

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Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions**: ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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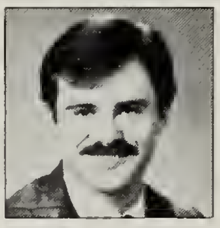

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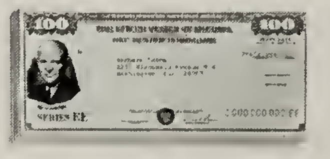

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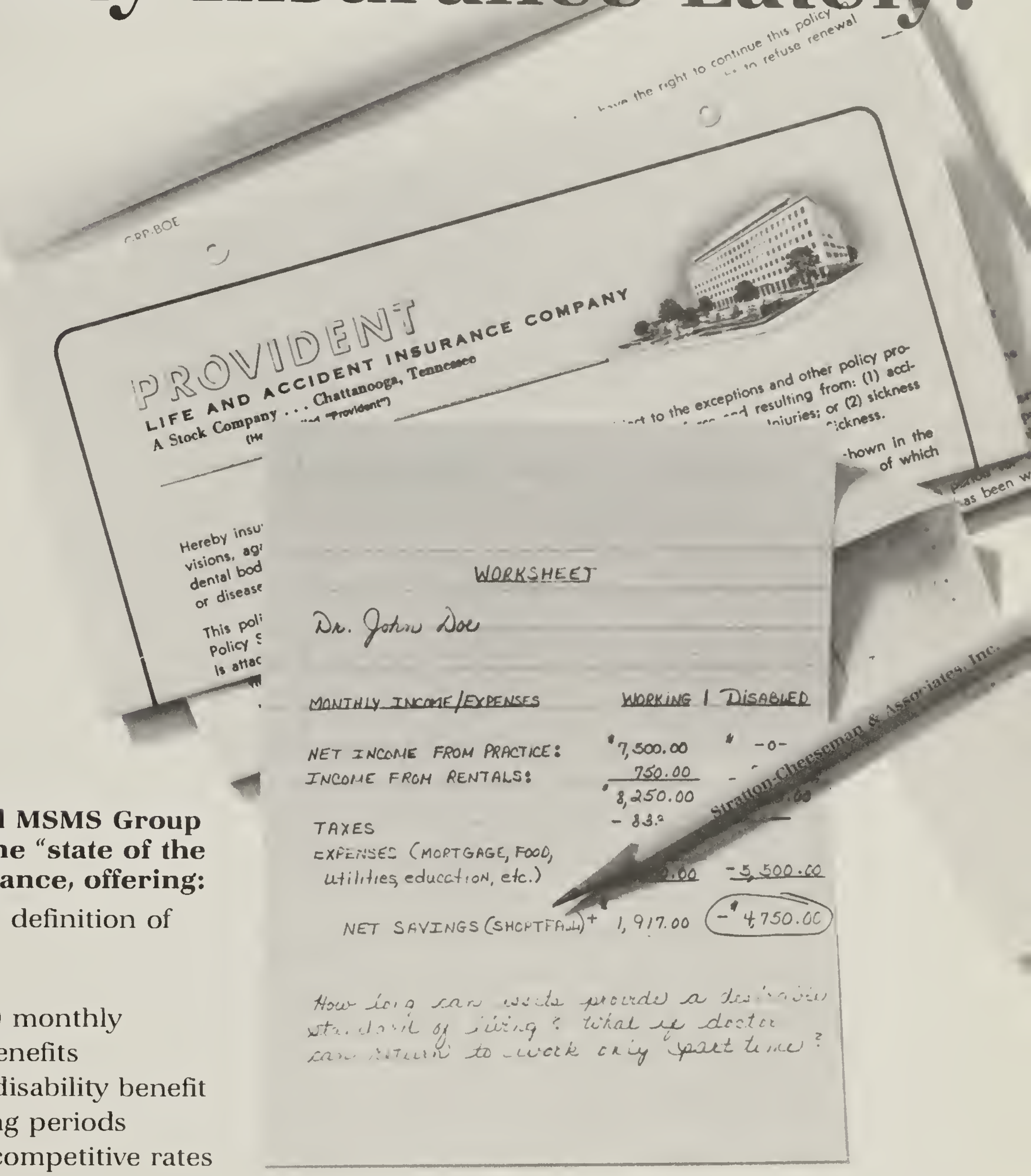
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> members of this court (footnoted citations omitted), we agree with the majority in *Brown* v *Siang*, 197 Mich App 191; 309 NW 2d 575 (1981); and *Cushman* v *Frankel*, 111 Mich App 604; 314 NW 2d 705 (1981), that a more detailed statement is unnecessary for a valid waiver. See also *Horn*, v *Cooke*, 118 Mich App 740; 325 NW 2d 558 (1982).
>
> The agreement specifically informs the patient of the right to trial by judge or jury and that arbitration is a substitute for trial.
>
> In signing the agreement, plaintiff Kathleen McKinstry expressly certified that she did "fully understand" the contents of the agreement. In the event of coercion or fraud in the execution of a particular arbitration agreement, the agreement, like any contact, is void of at least voidable. *Horn* v *Cooke*, *supra*; *Brown* v *Siang*, *supra*; *McKinstry* 146 Mich App 307, 311 (citing its prior opinion, 120 Mich App 479 (1982)).
>
> In this case we conclude that the arbitration agreements were valid waivers of the right to a jury trial. The court below found that defendants had complied with the act, there was no fraud or coercion, and that Kathleen McKinstry was in a sufficient physical and mental condition to sign a valid arbitration agreement. *McKinstry*, at 312.

Once it is determined that an arbitration agreement is in conformity with the MMAA requirements, placing the burden on the health care provider to prove a valid waiver by the patient of a jury trial would result in a practical impossibility. The health care provider is not in a position to demonstrate that a patient "knowingly, intelligently and voluntarily" waived the right to a jury trial. Only the patient could prove or disprove such facts. In most cases, hospital employees have no independent recollection of explaining the arbitration choice to a particular patient. Testimony from the hospital employee is generally limited to their usual and customary practice in presenting the arbitration choice to patients. The practical impact of placing such a burden of proof on the health care provider would be the elimination of the MMAA.

The arbitration agreements signed by Mrs. McKinstry were in complete conformity with the MMAA statutory requirements. The trial court below, after a full evidentiary hearing, held as a matter of fact that Appellants could not demonstrate any grounds for rescinding or invalidating the agreements. Based on these findings, the court of appeals appropriately affirmed the trial court's order to compel arbitration. MCR 2.613(c); *Kunath* v *Sinai Hospital of Detroit*, *supra*.

III. An unborn child is bound by an arbitration agreement signed on its behalf by a parent.

Section 5046 of the MMAA, in pertinent part, provides:

> A minor child shall be bound by a written agreement to arbitrate disputes, controversies, or issues upon the execution of an agreement on his behalf by a parent or legal guardian. The minor child may not subsequently disaffirm the agreement. MCL 600.5046(2); MSA 27A. 5046.(2).

While Appellants argue that Section 5046 does not apply to Plaintiff Amanda McKinstry because she was an unborn child at the time the arbitration agreement was signed on her behalf by her mother, the court of appeals below did not feel the Legislature intended to carve out such an exception:

> In construing a statute, we primarily seek to determine and give effect to legislative intent. *Nash* v *DAIIE*, 120 Mich App 568, 571 (1982), *lvden*, 417 Mich 1088 (1983). This court has recognized that the Medical Malpractice Arbitration Act was enacted in response to a medical malpractice crisis and, thus, as a remedial statute should be liberally construed to effectuate its purposes. *Miller* v *Swanson*, 95 Mich App 36, 43-44 289 NW 2d 875 (1980). . . .
>
> As indicated above, at common law a parent did not have the authority to bind a child to an arbitration agreement. (citation omitted).
>
> We believe that the purpose of Sec. 5046(2) is to grant parents that authority and thus enable many claims by minor children to go to arbitration. We do not believe that the Legislature was concerned in Sec. 5046(2) with the procedure for executing the agreement, Sec. 5041 and Sec. 5042 being addressed to that matter. We think it sufficient that Amanda is now a minor child and that she is seeking to disaffirm an agreement clearly executed on her behalf. *McKinstry*, 146 Mich App at 312-313.

Section 5046(2) changes the common law to permit a parent, within constitutional boundaries, to bind a minor child to an arbitration agreement. *Benson* v *Granowicz*, 140 Mich App 167, 169 (1984); *Harte* v *Sinai Hospital of Detroit*, *supra*, at 664. The courts have further recognized that the rights of a viable unborn child are similar to that of a minor child. *O'Neill* v *Morse*, 385 Mich 130 (1971); *Womack* v *Buckhorn*, 384 Mich 718 (1971); see also, *Roe* v *Wade*, 410 US 113 (1973).

Through the enactment of the MMAA, the Legislature sought to remedy a significant

Continued on page 383

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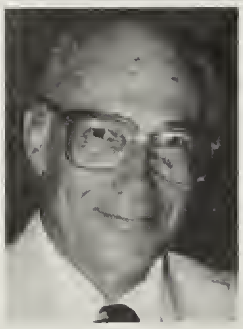
By Frederick W. Bryant, MD

Decline and fall?



Bryant

Recently I visited Italy, sampling ancient worlds and appraising their civilizations. History marched by: the individual brilliance of the masters—Leonardo, Michelangelo, Raphael; the architectural and administrative soundness of Rome and the might of the Caesars; the Church, the Popes, the Vatican; merchant states Venice and Genoa and the navigators who plied Marco Polo's old routes to the Orient and Columbus' new one to the Americas; art blooming briefly and basking under the benevolent patronage of the Medici in Florence (the name itself means flower!).

Impressive throughout is the earnestness and intensity of humanity's ambition, the electrifying potential of its capacities, and the tenacious ability to persist in one form or another through the centuries. But equally apparent is the fragility of civilization, the brevity and instability of achievements, the inordinate ebb and flow of fortune with severe regressions, oppressions—even extinction—of whole cultures and the individual suffering and collective tragedies attendant upon these negative extremes.

The greatest eclipse of man's progress occurred when the Roman Empire succumbed to internal and external forces and disintegrated. Her borders unprotected, a millenium of success and accomplishment lay in rubble at the feet of vandals and visigoths. Security became the paramount concern and fortifications sprang up around individual cities. But walls that protect also restrict. The petty-states were just that—isolated, ignorant rival factions involved in internecine warfare. Trade, refinement, learning— all of society retreated into history's darkest age. Civilization slumbered.

Medicine at ebb or flow?

I searched for current professional perspectives in time's ageless panorama. Where is medicine today? Ebb or flow?

In recent years legal assaults have devastated medicine, reducing enthusiasm and pride to pessimism and disenchantment. These assaults are of sufficient magnitude to alter and limit practice, bankrupt, decimate our numbers by defection and stultify recruitment, and the public is poorer for it. A system which fails to protect meritorious citizens involved in gainful pursuits endangers itself. There is too much injustice in our justice.

Earlier this century, but within the memory of our older members, uninvited foreign forces invaded medicine's borders. These corporate, economic, and governmental "third parties" trample our individual liberties and opportunities and grow ever more autocratic and strident as they intrude between us and the interests of our patients (their constituents too!). Reacting to growing evidence of inefficiency, extravagance and exploitation (all more obvious since they entered the arena) they preach a new protectionism: contraction is in order, austerity the theme. Eliminate universal trade, promote exclusiveness. Reduce benefits, curtail services, pay through a fixed system with no allowance for extraordinary service. Work in closed, cloistered groups. Reduce benefits, curtail services, pay through a fixed system with no allowance for extraordinary service. Work in closed, cloistered groups.

How often will the cost gatekeepers look beyond the portals for help or knowledge when their own interests and rewards lie within? And what of those beyond the walls—do they perish?

Have we entered a darker age? Will medicine's next tapestry be as finely woven as the last, its colors as bright, its artisans as varied? I wonder.

Pillar of the Church Simon Peter, lacking direction, inquired of a resurrected Christ he failed to recognize, "Domine, Quo Vadis?," variously interpreted as, "Sir, where do you go?" or, "Lord, where leadest thou?" We in medicine today, in the presence of our modern masters of commerce, industry and state, similarly might ask, "Whither the path? And what of quality along the way? How many tears for our fragile and precious flower, medicine?" ☐

Doctor Bryant is a member of the MSMS Board of Directors, chairs the Board's Scientific and Educational Affairs reference committee, and serves on the Board's Committee on Publications.

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FEWER SIDE EFFECTS IN ANTIANGINAL THERAPY

BRIEF SUMMARY

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist).

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic)

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension**. Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury**. In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes, however, these changes were reversible with continued dosing

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity There was also no mutagenic response in in vitro bacterial tests No intrinsic effect on fertility was observed in rats

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM (diltiazem hydrochloride) in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established The most common occurrences, as well as their frequency of presentation, are. edema (2.4%), headache (2 1%), nausea (1 9%), dizziness (1.5%), rash (1.3%), asthenia (1 2%), AV block (1 1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence

Cardiovascular	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System.	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia
Gastrointestinal	Constipation, dyspepsia, diarrhea, vomiting. mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity
Other	Polyuria, nocturia

The following additional experiences have been noted

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM. erythema multiforme; leukopenia, and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered

Bradycardia	Administer atropine (0.60 to 1 0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy
2. **Prophylactic Nitrate Therapy** — CARDIZEM may be safely co-administered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

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References: 1. *Physicians' Desk Reference*®, ed 39. Oradell, NJ, Medical Economics Company Inc, 1985. 2. Cohn PF, Braunwald E Chronic ischemic heart disease, in Braunwald E (ed) *Heart Disease A Textbook of Cardiovascular Medicine*, ed 2 Philadelphia, WB Saunders Co, 1984. chap 39 **3**. Schroeder JS Calcium and beta blockers in ischemic heart disease When to use which *Mod Med* 1982; 50(Sept).94-116. **4**. Subramanian VB Comparative evaluation of four calcium antagonists and propranolol with placebo in patients with chronic stable angina *Cardiovasc Rev Rep* 1984. 5.91-104. **5.** Schroeder JS, Feldman RL, Giles TD, et al Multiclinic controlled trial of diltiazem for Prinzmetal's angina *Am J Med* 1982; 72·227-231 **6.** Weiner DA, McCabe CH, Cutler SS, et al. The efficacy and safety of high-dose verapamil and diltiazem in the long-term treatment of stable exertional angina *Clin Cardiol* 1985; 7 648-653. **7.** Shapiro W Calcium channel blockers Actions on the heart and uses in ischemic heart disease. *Consultant* 1984. 24(Dec).150-159

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malpractice crisis which has overburdened the court systems in this jurisdiction and resulted in skyrocketing jury verdicts, insurance premiums and health care costs. It is clear that Section 5046(2) of this statute was aimed at allowing parents to bind their children, *all* their children, to arbitration rather than permit a child to subsequently avoid arbitration in favor of the courts at the age of majority. In view of this legislative purpose, a minor child born *after* parental consent to arbitration can not be distinguished from that of a minor child who was born *prior* to parental consent. The Legislature did not intend to create such a distinction. MCL 600.5046(2).

The exception for an unborn child which Appellants propound would have a far-reaching detrimental impact on the malpractice crisis which MMAA seeks to remedy. If Appellant's position was adopted, then all arbitration disputes brought by or on behalf of a child involving claims of birth trauma would be subject to avoidance. The Legislature could not have intended to create this exception to Section 5046(2).

Conclusion

Arbitration agreements drafted in conformity with the Medical Malpractice Arbitration Act provide patients with constitutional protections which assure that patients are fully informed when they voluntarily elect to waive a jury trial in favor of arbitration. Subsequent efforts by the patient to avoid arbitration should require the patient to bear the burden of proof that the signed arbitration agreement is invalid. Based upon the trial court's findings of fact, Appellants were unable to meet this burden.

The Legislature did not intend to exclude unborn children, like Appellant Amanda McKinstry, from those "minor" children bound by an arbitration agreement signed on their behalf by a parent. The purpose of the statute, as the court of appeals opined, is to remedy the medical malpractice crisis and, therefore, attempt to limit the number of cases in our court system. Acccordingly, the MMAA meant to include and bind all children to arbitration, whether born or unborn at the time the arbitration agreement is signed, when a parent signs an arbitration agreement on their behalf.

Relief requested

For the foregoing reasons, Michigan State Medical Society respectfully requests that this Court affirm the decision of the court of appeals. ☐

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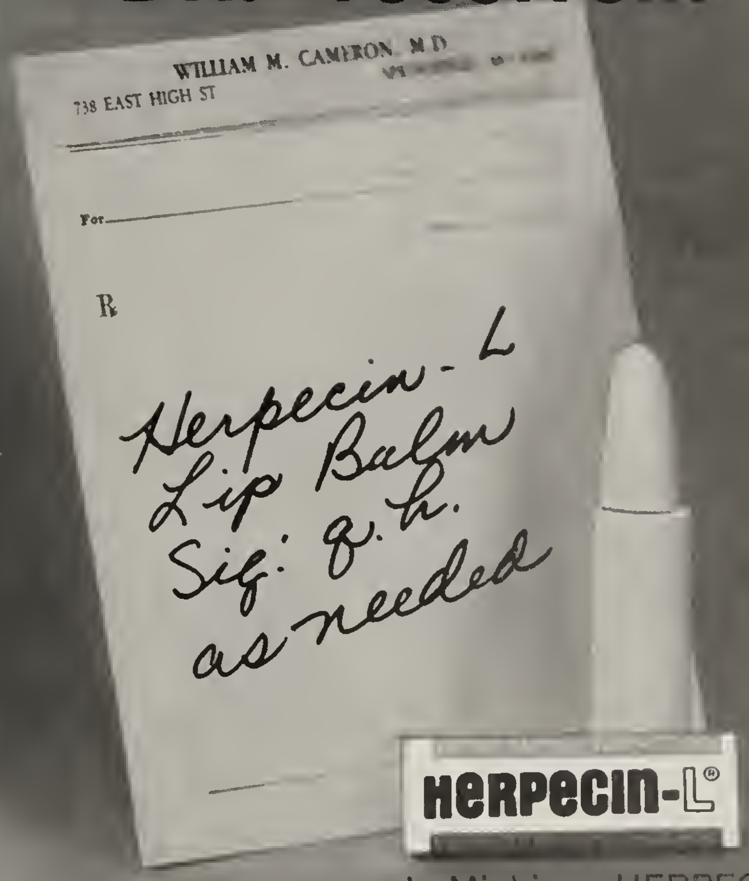

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PHYSICIANS IN THE NEWS

Douglas B. McKeag, MD, MSU associate professor of family practice, led a 40-member delegation of US primary care/sports medicine specialists in a tour of medical facilities and an exchange of technical information in the People's Republic of China.... **Harry A. Towsley, MD,** Ann Arbor, former chairman of post graduate medicine at the University of Michigan Medical Center and **Scott W. Woods, MD,** Ypsilanti surgeon, have been named to the Board of Trustees of Cleary College, Ypsilanti. ... **Baruch S. Blumberg, MD,** presented the 65th Annual Beaumont Lecture entitled "The Biology of the Hepatitis B Virus." Doctor Blumberg won the Nobel Prize in Physiology or Medicine in 1976 for his work with hepatitis.... **Robert W. Leader, DVM,** East Lansing, professor of pathology, has been named president-elect of the International Academy of Pathology, an organization dedicated to the advancement of research, education and teaching in pathology.... **Myron LaBan, MD,** Royal Oak, was guest lecturer at the Ohio State University Department of Physical Medicine's 7th Annual Sidney Licht Lecture Series. Doctor LaBan is Director of Physical Medicine and Rehabilitation at William Beaumont Hospital. ... **Samuel McMahon, MD,** Lansing, vice president of Medical Affairs at Ingham Medical Center spent May and June in China on a touring and teaching expedition. Doctor McMahon focused on Chinese physicians' approach to air pollution and industrial lung disease problems.... **Fleming A. Barbour, MD,** Flint, was named 1985 Health Advocate of the Year by the American Lung Association of Genesee Valley for his work in providing eye care and glasses for the needy in Third World countries.... **Ronald Selbst, MD,** Bloomfield Hills, director of professional services at Kingswood Hospital, has been named president-elect of the Michigan Psychiatric Society. ... **Alexander J. Walt, MD, FACS,** Detroit, has been named to the Board of Regents of the American College of Surgeons.... **Jack Ryan, MD,** Detroit, President and Chief Executive Officer of the Detroit-Macomb Hospital Corporation was recently awarded Fellowship in the American College of Physician Executives during its 1986 National Conference on Health Care Leadership and Management in Monterey, California. ... **Thomas H. Swanson**, a fourth year medical student, was the winner of the 1986 G. Milton Shy Award in Clinical Neurology, sponsored by the American Academy of Neurology for his essay entitled "Creutzfeldt-Jakob Disease." ... **Michael S. Dahn, MD,** Mt. Clemens, assistant professor of surgery, was presented with the Stanley Dudrick Research Award and Scholarship for investigative work in nutrition and metabolism.... **Yvan J. Silva, MD,** Detroit, professor of surgery, was awarded an honorary fellowship for distinguished and meritorious services in academic surgery by the Academy of General Education in Manipal, India. ... **George W. Morley, MD,** Ann Arbor, has been elected the 1987 president of the American College of Obstetricians and Gynecologists. ... **Michael C. Kozonis, MD,** Pontiac, and **Raymond A. Gagliardi, MD,** Pontiac, have been awarded the 1985 Distinguished Service Award by the St. Joseph Mercy Hospital Boosters Club for their exceptional leadership and support of Boosters activities.... **Habib Vaziri, MD,** Bloomfield Hills, has been named the new chief-of-staff of the St. Joseph Mercy Hospital Medical Staff. Doctor Vaziri is an assistant professor of psychiatry at both Wayne State University and Michigan State University.... **John J. Voorhees, MD,** Ypsilanti, has been awarded the Taub International Memorial Psoriasis Research Award for his significant advances in the understanding or treatment of psoriasis. Doctor Voorhees is professor and chairman of dermatology at The University of Michigan Medical Center.... **J. Timothy Greenamyre**, a fourth-year student at the University of Michigan Medical School, has won the Roland P. Mackay Award from the American Academy of Neurology for his essay "The Role of Glutamate in Neurotransmission and in Neurologic Disease." ... **Daniel Cardona** and **Steven Clark,** students at The University of Michigan Medical School have been named 1986 Commonwealth Fund Fellows for outstanding academic performance.... **Hershel Sandberg, MD,** Southfield, has been chosen to receive the Distinguished Alumni Service Award by his fellow alumni of the Wayne State University School of Medicine acknowledging his dedication as a physician and community leader.... **Russell N. Van Houzen, MD,** Traverse City, has been elected to the fellowship of the American College of Physicians. Doctor Van Houzen is chief of medicine at Munson Medical Center.... **Janusz A. Subczynski, MD**, Harper Woods, has been elected president of the Southeastern Michigan Surgical Society. Other new officers of the society are **David B. Hawtof, MD,** Southfield, president-elect, and **Ronald E. Cheek, MD,** Detroit, secretary. **Norman A. Bolz, MD,** Harper Woods was re-elected as treasurer. New council members are **Arnold G. Coran, MD,** Ann Arbor, and **David A. Penner, MD,** Royal Oak.☐

Mutual Memo

2

How communications can help prevent medical liability claims

Second in a series

Doctor, Here are Four Communications Tips to Help You Prevent an Insurance Claim:

Communicate personally with your patients. Talk to patients in language they understand, with an empathetic attitude, and you'll increase their satisfaction with your care.

Give patients written information. Avoid misunderstandings. Hand out fact sheets or booklets to explain home care, office hours, emergency call procedures, and other matters.

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How to effectively handle medical liability claims is the subject of MPMLC's annual seminar for defense attorneys. “Building an aggresive team which works for physicians is one of the seminar's primary objectives,” states Fred Phelps, vice president of claims.

“Our defense seminar allows insurance professionals and lawyers to exchange new information for strengthening cases, closing them faster, and reducing costs,” Phelps adds.

State Senator Alan Cropsey, sponsor of tort reform legislation, was the keynote speaker at this year's seminar. Pathologist Charles Sander, MD, told participants about placenta research which can be used to defend birth trauma cases.

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MSMS, MSMS/A, AMA & MEDICAL ASSISTANTS

July 17-20 — MSMS Midsummer Board of Directors meeting, St. Clair Inn, St. Clair, contact: William Madigan (517)337-1351.

August 22 — Practice Management Seminar: Computers in the Medical Practice, Boyne Mountain, Boyne Falls, contact: Donna Farougi, MSMS headquarters (517)337-1351.

September 5-6 — AMA Council on Medical Service, "Increased Competition in Medicine: Effective Physician Responses," Westin O'Hare Hotel, Chicago, contact: Mark Stuart 1-800-621-8335.

September 10 — MSMS Board of Directors Meeting, MSMS headquarters, East Lansing, contact: William Madigan (517) 337-1351.

November 19 — MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, contact: William Madigan (517) 337-1351.

OTHER MEETINGS

July 18-20 — Michigan Medical Assistants "Sailing into the Sea of Knowledge," Holidome, Benton Harbor, contact: Caroline Rich, MSMS Headquarters, East Lansing (517)337-1351.

July 23, 12:00 noon — Council Meeting, Michigan Chapter of the American College of Surgeons, Grand Traverse Resort, contact: Viola M. Heins, executive secretary, MSMS headquarters (517)337-1351.

July 25 — Board Meeting, Michigan Society of General Surgeons, Grand Traverse Resort, contact: Caroline Rich, MSMS headquarters (517) 337-1351.

July 28-30 — Michigan Academy of Family Physicians 40th Annual Scientific Assembly, Traverse City, contact: MAFP, 109 E. Oakland, Lansing 48906 (517)482-7401

November 7-9 — Michigan Medical Assistants "Grand Affair," Amway Grand Plaza Hotel, Grand Rapids, contact: Caroline Rich, MSMS Headquarters, East Lansing (517)337-1351.

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ichigan Medicine each month carries a list of opportunities in Michigan for doctors medicine to obtain Category I credit toward meeting the requirements of Michigan v. Sponsors of Category I programs and courses in Michigan are invited to submit ormation for the monthly calendar.

ch listing below, of programs that carry at least 3 hours of Category I credit, indicates contact person, so the physician can obtain details. Physicians with questions about credited programs may phone MSMS headquarters, (517) 337-1351.

te: July 24-26, Clinical Nutrition Up- te. Location: Towsley Center, Ann Ar- r. **Sponsor:** University of Michigan Med- al School. **Contact:** Janet Boomer, wsley Center, Box 0201, University of ichigan Medical School, Ann Arbor 3109-0010 (313)763-1400. **Approved r:** 11.5 hours of Category I Credit.

te: July 24-25, Coller Penberthy Thirlby edical Conference. Location: Grand averse Resort, Grand Traverse Village. **onsor:** Munson Medical Center. **Con- ct:** Norma Powers, Coordinator of Med- al Education, Munson Medical Center, h and Madison, Traverse City 49684 16)922-9544. **Approved for:** 9 hours tegory I Credit.

te: July 26-28, Advances in the Man- gement of Infectious Diseases. Loca- n: Grand Hotel, Mackinac Island. **Spon- r:** University of Michigan Medical hool. **Contact:** Betty Phillips, Office of ntinuing Medical Education, University Michigan Medical School, Towsley Cen- r, Box 0201, Ann Arbor 48109-0010 13)763-1400. **Approved for:** 10.3 urs of Category I Credit, 10.3 hours of AFP credit.

Date: August 1-3, Fabric of Mental Health: Our Common Threads. Location: Grand Traverse Resort, Traverse City. **Sponsor:** Michigan Psychiatric Society. **Contact:** Michigan Psychiatric Society, 21700 Northwestern Highway, Suite 1150, Southfield 48075. **Approved for:** 9 Hours of Category I Credit.

Date: August 1-3, Tutorial on Level II Myofascial Release Technique. Location: Homestead Resort, Glen Arbor. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing (517)353-9714. **Approved for:** 24 Hours of Category I Credit.

Date: August 14-17, 18th Annual Summer Conference. Location: Grand Hotel, Mackinac Island. **Sponsor:** Michigan Ophthalomological Society. **Contact:** Jane Panin, 412 Eastland Center Professional Building, Harper Woods 48225-1084 (313)839-3011. **Approved for:** 8 hours of Category I Credit.

Date: August 17-20, Internal Medicine Update. Location: Grand Hotel, Mackinac Island. **Sponsor:** University of Michigan Medical School. **Contact:** Gayle Fox, Towsley Center, Box 0201, University of Michigan Medical School 48109-0010 (313)763-1400. **Approved for:** 11.1 hours of Category I Credit, 11.1 hours of AAFP credit.

Date: September 3, Update '86—Rehabilitation of Traumatic Brain Injury. Location: Kalamazoo, Michigan. **Sponsor:** West Michigan Physiatry, PC and Southwestern Michigan Area Health Education Center. **Cost:** $50. **Contact:** Doctor Bryan Visser, West Michigan Physiatry, PC, 252 E. Lovell Street, Suite 363E, Kalamazoo 49007. **Approved for:** 5.75 hours of Category I Credit.

Date: September 6, Basic Cardiac Life Support Course for Physicians. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Date: September 6-7, Chief Surgical Residents. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Continued on next page

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Date: September 7-8, Advanced Cardiac Life Support Provider Course. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School (313)763-1400. **Approved for:** 16 hours of Category I Credit.

Date: September 11-13, Grand Rapids 17th Annual International Symposium on Implant Surgery for the Hand, Upper Extremity, and Foot. Location: Blodgett Memorial Center and Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** Michigan State University College of Human Medicine and International Federation of Societies for Surgery of the Hand. **Contact:** Alfred B. Swanson, MD, Blodgett Professional Building, Suite 290, 1900 Wealthy Street, SE, Grand Rapids 49506. **Approved for:** 18 hours of Category I Credit.

Date: September 12-13, Parenteral and Enteral Nutrition 1986: Clinical Update. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: September 12-13, Hypertension 1946-1986: The First Ann Arbor International Reunion. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 481090010 (313)763-1400. **Approved for:** 12 hours of Category I Credit.

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Date: September 13-17, Tutorial on Level I Muscle Energy Technique. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: September 25-27, repeated November 13-15, Neonatal/Infant/Child Life Support. Location: Gilmore Health Education Center, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association and Southwestern Michigan Area Health Education Center. **Contact:** William H. Scott, MD, Southwestern Michigan Perinatal Association, 252 E. Lovell Street, Kalamazoo 49007 (313)383-6469. **Approved for:** 19 hours of Category I Credit.

Date: September 25-27, Diagnostic Ultrasound. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 15 hours of Category I Credit.

Date: September 26-28, American Academy of Pediatrics, Michigan Chapter 37th Annual Scientific Meeting. Location: Hilton Shanty Creek Summit Conference Center, Bellaire. **Sponsor:** Michigan Chapter, American Academy of Pediatrics. **Contact:** Mr. P. Miles Tiernan, 32245 Hearthstone, Farmington Hills 48018. **Approved for:** 7 hours of Category I Credit.

Date: September 26-28, Tutorial on Level I Myofascial Release Technique. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 24 hours of Category I Credit.

Date: September 29-October 1, Hemodynamic Monitoring and Management Seminar. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 14 hours of Category I Credit.

Date: October 1-3, Mechanical Ventilatory Support and Management. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313) 763-1400. **Approved for:** 15 hours of Category I Credit.

Date: October 2-3, Diabetes Care. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsl Center, Box 057, University of Michig Medical School, Ann Arbor 48109-001 (313)763-1400. **Approved for:** 16 hou of Category I Credit.

Date: October 3, 16th Annual Cardiolo Symposium. Location: Kalamazoo Hilt Inn, Kalamazoo. **Sponsor:** Borgess Me ical Center; Kalamazoo Chapter of t American Heart Association; Michig Academy of Family Physicians. **Conta** E. Enrique Leguizamon, MD, Borgess Me ical Center, 1521 Gull Road, Kalamaz 49001 (616)383-5930. **Approved for** hours of Category I Credit.

Date: October 4-5, National Conferen for Chief Medical Residents. Locatio Towsley Center, Ann Arbor. **Sponso** University of Michigan Medical Scho **Contact:** Anne Karolak, Towsley Cent Box 057, University of Michigan Medic School, Ann Arbor 48109-0010 (31 763-1400. **Approved for:** 10 hours Category I Credit.

Date: October 9-10, Ear, Nose and Thro Practicum. Location: Towsley Center, A Arbor. **Sponsor:** University of Michig Medical School. **Contact:** Jolene Glaspi Towsley Center, Box 0201, University Michgian Medical School, Ann Arb 48109-0010 (313)763-1400. **Approve for:** 17.25 hours of Category I Credit, 17 hours of AAFP credit.

Date: October 9-10, Ins and Outs of Cri ical Care: Fluids, Nutrition and Ren Management. Location: Towsley Cente Ann Arbor. **Sponsor:** University of Mic igan Medical School. **Contact:** Ann Karolak, Towsley Center, Box 057, Unive sity of Michigan Medical School, Ann A bor 48109-0010, (313)763-1400. **A proved for:** 12 hours of Category I Credi

Date: October 11-15, Tutorial on Level Manual Medicine Techniques (Abo Diaphragm). Location: Kellogg Cente MSU. **Sponsor:** MSU College of Oste pathic Medicine and College of Huma Medicine. **Contact:** Sandy Kilbourn, Dire tor of Continuing Medical Educatio MSU, A306 E. Fee Hall, East Lansin 48824 (517)353-9714. **Approved for:** 4 hours of Category I Credit.

Date: October 16-17, Perinatology an Neonatology. Location: Towsley Cente Ann Arbor. **Sponsor:** University of Mic igan Medical School. **Contact:** Jan Boomer, Towsley Center, Box 0201, U- Medical School, Ann Arbor 48109-001 (313)763-1400. **Approved for:** 13.2 hours of Category I Credit.

Date: October 16-18, Common Surgic Problems in Childhood. Location: Tow ley Center, Ann Arbor. **Sponsor:** Unive sity of Michigan Medical School. **Contac** Anne Karolak, Towsley Center, Box 05 U-M Medical School, Ann Arbor 4810 0010 (313)763-1400. **Approved for:** 1 hours of Category I Credit.

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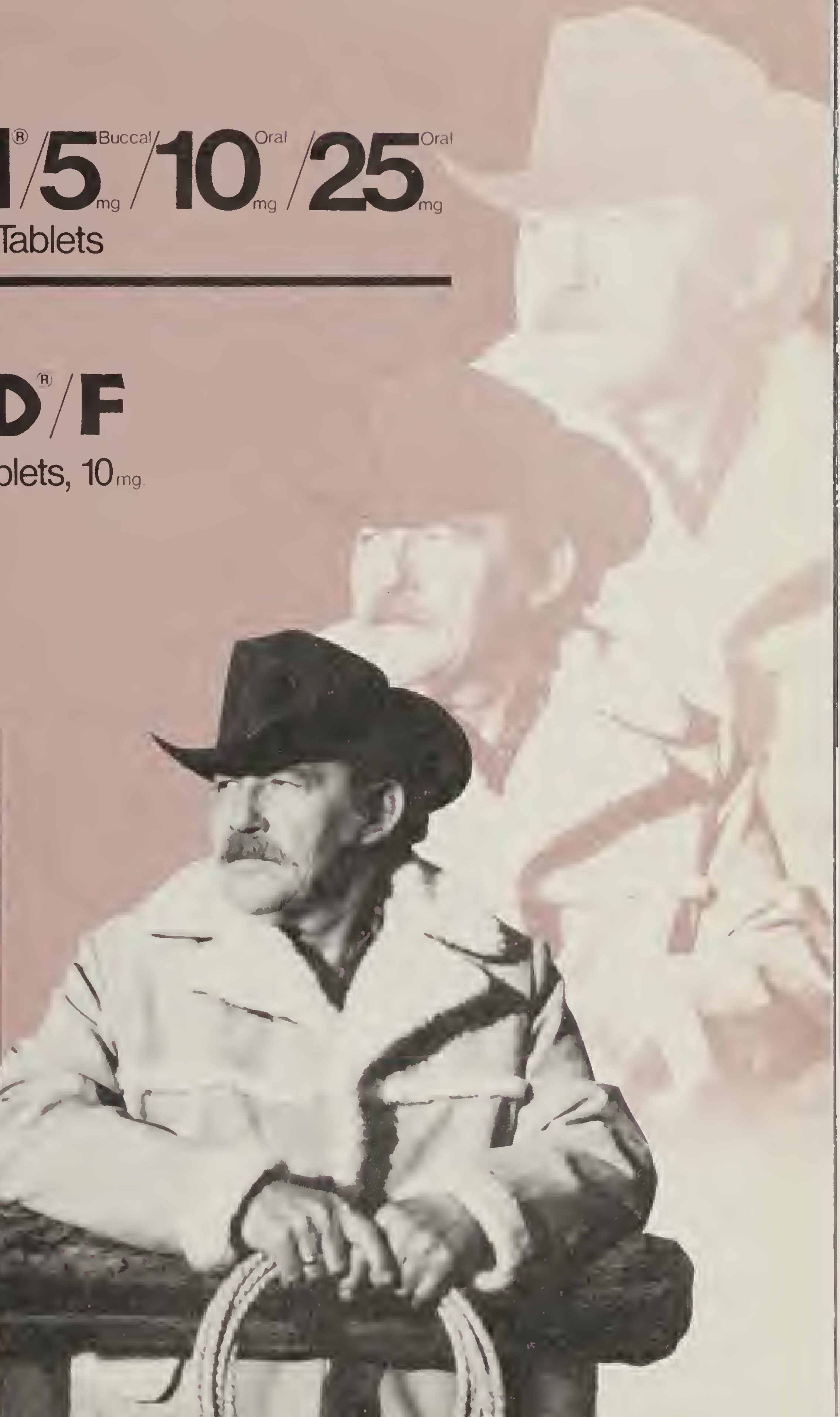

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Board of Medicine actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: John B. Bryan, MD
Action, Date Taken: Probation (2 yrs.) effective March 19, 1986.
Reason: Conduct, practice or condition which impairs, or may impair, ability to safely and skillfully practice the health profession.

Name: Frederick C. Greiling, MD
Action, Date Taken: Suspended License (60 days) effective May 1, 1986.
Reason: Departed from or failed to conform to minimal standards for acceptable and prevailing medical practice.

Name: Robert Sosa, MD
Action, Date Taken: License Revoked effective March 13, 1986.
Reason: Convicted of a crime reasonably related to and adversely affecting his ability to practice in a safe and competent manner. (Criminal sexual conduct, first degree) Lack of good moral character.

Name: Donald F. Bosker, MD
Action, Date Taken: Suspended License for period of one (1) month and probation one (1 year effective May 26, 198
Reason: Practice below minimal standards of acceptable and prevailing practice

Name: Edward Jenner Howar MD
Action, Date Taken: Summar Suspension effective April 1 1986.
Reason: Continued licensure constitutes an imminent thre to the public health, safety a welfare requiring emergency action.

Name: George Hansing Ong,
Action, Date Taken: Suspend License for minimum period one (1) year effective April 1 1986.
Reason: Departed from or failed to conform to minimal standards of acceptable and prevailing medical practice; convicted of a misdemeanor reasonably related to and adversely affecting his ability to practice in a safe and competent manner. (Medicaid Fraud-04/10/85 Ingham Coun Circuit Court file #85-53976-FH).

Name: Robert J. Sillery, MD
Action, Date Taken: Suspend License two (2) years effectiv April 29, 1986.
Reason: Michigan Supreme Court denied Doctor Sillery's application to appeal the Michigan Court of Appeals decision affirming the Michig Board of Medicine's order.☐

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FAMILY PRACTITIONER OR INTERNIST. Opening with the State of Michigan to provide inpatient medical care at the Coldwater Regional Mental Health Center. Facility has recently opened a geriatric psychiatric unit (150 beds) and will also have an acute psychiatric unit (60 beds). Psychiatric staff has an affiliation with the Department of Psychiatry at Michigan State University. Facility also includes some developmentally disabled patients for an overall total of approximately 275 beds. Salary in the mid 80s depending on qualifications. Fringe benefits and hours attractive. Coldwater is located 60 miles south of Lansing and provides a fine community and recreational area. Contact: Jerold P. Veldman, MD, FAAP, Medical Director, Coldwater Regional Mental Health Center, 620 Marshall Road, Coldwater 49036 (517)279-9551.

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By Thomas R. Berglund,

1986—it is a very good year

It sure was great to be forty-two! I had been in practice 15 years, and it was mature. My schedule was full and many of the patients were friends. Medical school and early practice debts were paid. I had enough gray so my older patients didn't think I was still wet behind the ears and I was young enough so I could relate to the teeny boppers. The malpractice crisis of 1974-1975 was behind us. My children were both in high school. I had been chairman of MDPAC for two years and had been elected an alternate delegate to the AMA. Gosh! I sure would have loved to have frozen life in 1976!

Unfortunately my children graduated from high school and went to college. My hair got grayer. My younger partners began telling me about things I had missed and new therapies I didn't know about. My young patients began to think of me as old and my older patients identified with me. Increasing numbers of doctors made my schedule less full and the malpractice crisis returned!

Time marches on

It really would be great if we could *freeze* life at some given time but we can't. *Time marches on,* as the newsreel used to proclaim. Things will be different tomorrow than they were today and you can bet on it. And things today aren't that bad! (I like running water, indoor toilets, refrigeration, furnaces, modern cars, microwave ovens, TV, antibiotics, polio vaccine, etc.)

Recently one of my friends said, "You know, not everything about the HMO is bad!!" I couldn't agree more. We have learned that preadmission laboratory testing is cost effective, as are same-day admissions, early ambulation and discharge, in-home IV antibiotics, to name a few. We may even experiment with sending OB patients home early and have either *visiting nurses* or "Magic Maids" visi them. It sure would save a lo of money.

I've also heard a lot of grumbling about DRGs and y know they haven't been all b either. I now can get a *sick* p tient admitted directly to the hospital. Hospitals are no longer full of patients who shouldn't be there. We are n longer rewarded for ordering the most lab tests. Administrators (President and CE are the new terms) love you when you arrange for early discharge. Home health care i in.

Yeah, 1976 was a very goo year. But so is 1986. Sure, w have to learn to get along wi HMOs, PPAs, DRGs and anoth malpractice crisis. I'm too old to change professions and besides, I like what I'm doing.

But, some things need chan ing and the things that don't need changing will!! But I'd rather be in the *mainstream* trying to make these changes work rather than sitting in the back of the room, throwing rocks, and yearning for the good old days! Rather than complain about how bad things are, get involved in some aspect of MSMS and exert a positive influence on yo future!!☐

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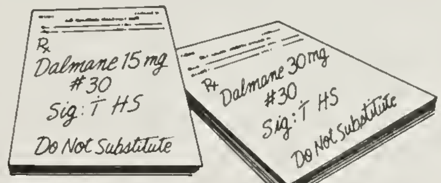

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Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported Also reported headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e g* excitement, stimulation and hyperactivity

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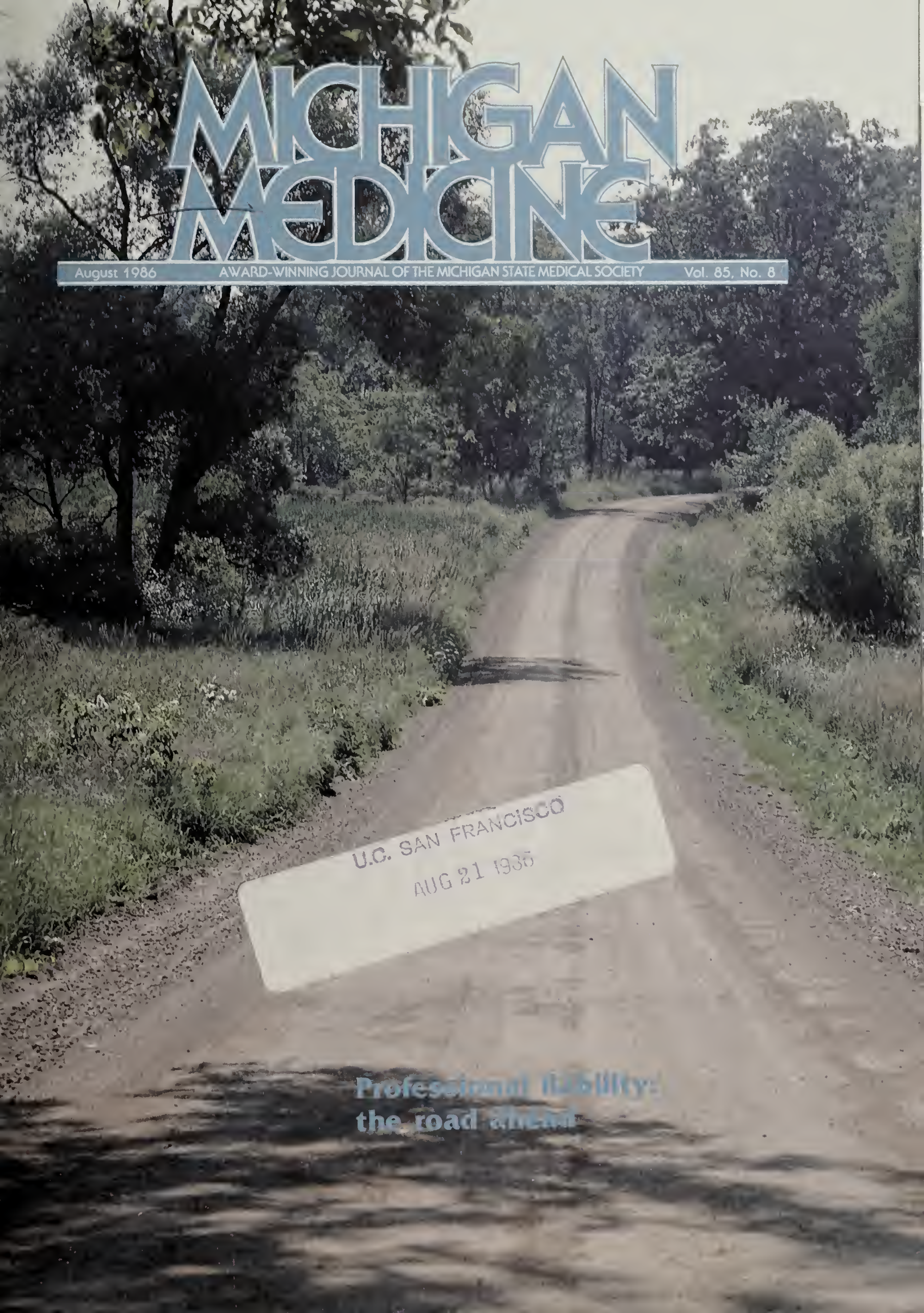
MICHIGAN MEDICINE

August 1986 AWARD-WINNING JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 85, No. 8



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Professional liability: the road ahead

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August 1986, Vol. 85, No. 8

MICHIGAN MEDICINE

bout the cover: What lies on
he road ahead as far as liabil-
ty reform is concerned?
SMS continues to map out
n effective course. **Photo by
im Kauffman.**

**n next month's issue of
*ichigan Medicine:*** The 1986
SMS Annual Scientific Meet-
ng will put you at "The Cut-
ing Edge" of developments in
edical care. Save these
ates — November 11-12-13
– and plan to join your col-
eagues at the Hyatt Regency
earborn. Our September
ssue will highlight this year's
pecial guests and topics.

Special Report

401 "MSMS will continue its legislative attempts at further tort reform this fall." That's the opening line of one section in our Special Report, and it reflects MSMS' resolve to continue to fight for effective relief from the liability crisis. Articles here discuss further tort reform proposals involving arbitration and physician countersuits; steps each member can take to further reform efforts; the need to emphasize arbitration as an alternative to the court system, and whether or not the recent legislation will help curb liability insurance premiums. Also inside are articles from the co-chairmen of the House/Senate conference committee on liability reform describing their negotiations. Photos of recent liability work sessions round out the Special Report: Sen. Daniel DeGrow; Rep. Lewis Dodak; Robert M. Leitch, MD; Rhoda M. Powsner, MD, and Frances Hamermesh; Richard D. Weber and Louis R. Zako, MD.

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By Richard Rapport, MD

How MSMS works

Recently we have become aware that a significant number of Michigan State Medical Society members do not understand the way in which their state society functions.

The MSMS policy-making body is composed of delegates elected from each of fifteen districts in proportion to the number of physician members. Also represented in the House of Delegates are medical school deans, the hospital medical staff section, medical students, resident physicians and the various specialty societies.

At the annual meeting in May resolutions are referred by the Speaker of the House to one of several reference committees before which any MSMS member may testify. Others also may testify with permission of the chairperson of the reference committees. After all the testimony has been heard, each resolution is reported to the full House of Delegates along with reference committee recommendations which may, after debate, be accepted, rejected or amended by majority vote of the delegates.

Since the House of Delegates meets only once each year the Board of Directors (elected by delegates to represent each district) meets regularly and is responsible for decision-making in the interim. The Board also conducts the day-to-day business of the Society. Subjects for discussion are referred to one of four standing committees of the Board which, after thorough research and debate, make recommendations to the entire Board for action. On occasion ad hoc committees are appointed by the Board chairman to research subjects requiring more extensive study. All Board actions are reviewed and may be approved, amended or disapproved by delegates at their annual meeting.

Since it is impossible for all delegates (or all directors) to be thoroughly informed on every subject, responsibilities are distributed according to interests and knowledge. Decisions are seldom unanimous, but usually a clear majority is established. In those rare instances when there is evidence that decisions may not represent the opinion of the majority of members, the House of Delegates has recommended membership polls to resolve the question (e.g. the recent abortion poll). Such polls are expensive to conduct and seldom, if ever, disagree with the original decision.

The House of Delegates of the American Medical Association meets twice each year. You are represented by delegates elected from the

Continued on facing page

Doctor Rapport is a member of the MSMS Board of Directors, and a member of the Committee on Publications.

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Michigan Medicine, the official journal of the Michigan State Medical Society, dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. *Michigan Medicine* reserves the right to accept or reject advertising copy. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

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Category I confusion

Your article on accredited CME programs, page 232, of the May 1986 *Michigan Medicine* gave me chest pain. The American College of Physicians (ACP) which certifies internists and produces the MKSAP VII (150 hours of category I credit) was not mentioned.

However, I understand that the Michigan Board has reciprocity with nationally certified CME and the ACP falls into this category.

Please clarify this for me and the other several thousand internists who are toiling through some of the most mentally taxing CME under the sun.

Gerald Stipanuk, MD
Charlotte

HOW IT WORKS/Continued

MSMS House of Delegates in proportion to AMA membership (currently eleven delegates and eleven alternates) and by four specialty society delegates. Decisions are made between meetings by the AMA Board of Directors which receives continuing reports from standing committees.

Rest assured that you are well represented. You will be best represented when you convey your own informed opinions to your delegates at both the state and national level. If you feel that decisions are incorrect your only recourse is to be vocal and, if necessary, vote to replace your elected delegates.

Organized medicine can be politically effective and can influence public opinion only if it represents a significant majority of physicians. Your membership is essential to protect the interests of us all.☐

MSMS received several inquiries similar to those expressed by Doctor Stipanuk in response to the list of hospitals and institutions accredited to present Category I CME activities we published in the May issue of *Michigan Medicine*. We will try to clarify this matter for you.

The Michigan Board of Medicine only accepts, towards the requirements for relicensure, those Category I CME credits that have been granted by hospitals and/or organizations that have been accredited either by the Michigan State Medical Society Committee on CME Accreditation or the Accreditation Council for Continuing Medical Education, the national accrediting body. Although the Board of Medicine has approved the CME accreditation standards of MSMS and ACCME, it reserves the right to deny approval of programs offered by these hospitals and organizations "whenever it appears to the Board that the program offered by those institutions and organizations fails to demonstrate compliance with the legislative intent to further educate licensees on subjects related to the practice of medicine."

The list that appeared in the May issue of *Michigan Medicine* contained the names of the Michigan hospitals and organizations that have been accredited by the MSMS Committee on CME Accreditation to present Category I CME programming. The credits they grant are accepted by the Michigan Board of Medicine toward relicensure.

Category I CME credits granted by the over 400 hospitals and organizations accredited by Accreditation Council for Continuing Medical Education (ACCME) also are accepted by the Michigan Board of Medicine toward relicensure. A list of these nationally accredited bodies was not published in *Michigan Medicine*; however, the list of ACCME accredited institutions is on file at MSMS. This information also may be obtained by calling ACCME in Lake Bluff, Illinois at (312)295-1490.

For further information, call Katie Brewbaker at MSMS headquarters, East Lansing (517)337-1351.☐

Petitions and constitutional government

I am compelled to write, not as Speaker of the House of Delegates, but as an individual physician about petitions circulating seeking to amend our state constitution to limit contingency fees. Recently our MSMS Board of Directors took action to support the petition drive that began as a private citizen's initiative. The action taken was in response from membership pressure to do something more for liability reform than will the legislation. The initiative was discussed by the Board immediately following the annual meeting. There was prolonged discussion whether it was appropriate to take a stance or not. Some directors could see no problem in supporting the petition drive; a few, including myself, were adamant that our state constitution was an inappropriate vehicle for this kind of tort reform.

I believe it necessary to lay out the issues in this potentially divisive matter, hence this letter.

The current tort system is costly. Only 20 to 25 percent of awards reach the claimants. The tort system is unfair. It is accusatory and demeaning. Many verdicts appear unjust. Too often emotions and not fact are the basis for judgments. There are "hired gun"

Continued on page 400

witnesses, uninformed juries, uninformed judges, excessive awards, some frivolous suits, inability to countersue and a lottery mentality not tied to malpractice or negligence, but rather outcome. The tort system allows joint and several liability and "deep pocket" recovery, an outrage on the concept of fairness and a smear on our legal system.

Worthy physicians are driven out of practice, forcing early retirement and a reduction in service on behalf of the public. The system causes emotional pain and suffering to defendant physicians to an extent little realized by the public. The current tort system causes an adversary doctor-patient relationship; it pits colleague against colleague and hospital against doctor. Lastly, contingency fee arrangements allow anyone to sue provided an attorney will take the case. The current tort system threatens bankruptcy to doctors and confiscation of a physician's life savings.

A burden

The current tort system in Michigan cannot support 12,000 suits in six years against 4,500 doctors when settlements are $125 million and have a projected indemnity of $210 million, and when the risk is weighed heavily toward some practitioners and not others. Incidentally, these figures do not include suits against hospitals and the costs of hospital liability.

The system cries out for reform. That is why more than 10,000 people marched on Lansing to demonstrate the seriousness of the problem. That is why the legislature enacted a number of tort reform bills which we hope will pass constitutional challenge. The new laws are a beginning: to some a moderate success; to others a dismal failure.

Relief from liability will under no circumstances be immediate. Premiums will almost certainly continue to escalate until current tort reform measures have been in place for at least two years and then, only slowly, will the trend stabilize or move downward.

The contingency fee is only one unresolved issue. Of others, consider these: mandatory arbitration; mandatory liability insurance; a patient compensation trust; a risk management system; a strengthened Board of Medicine; no-fault liability; a realistic cap on pain and suffering. No wonder many of us clutch at straws, remain angry and rush to take matters into our own hands.

On the other hand, consider that there is far less than perfect care; that negligence and poor judgement occur; that some physicians do not listen to their patients; that some physicians are rushed, fatigued, incompetent, occasionally alcoholic, and sometimes drug addicts; that some physicians have poor to non-existent documentation of their records. Consider that Nature is a demanding task mistress keeping us humble when dealing with illness. Consider the high expectations our advances in science have given the public.

The arguments against limiting contingency fees

1. The medical liability issues are complex, as we know. How realistic is a petition drive to limit contingency fees in resolving our crisis? The petition suggests no change in the first $100,000 of any settlement from current law. Is any suit not worth pursuing if $30,000 is a beginning fee? Does it really matter to an attorney whether or not he achieves an award of $500,000 or $1 million if his fee will be "A" vs "B"? May he not fight even harder to reach a larger award? Once the base fee is established, there is no reason to seek any lesser amount. The limitation on co tingency is thus a delusion. U derstandably petitioners are justified in alleging that large awards unduly enrich the poc et of the attorney. Legal and judicial redress is the answer, and not constitutional reform

2. Our constitution is a vita document. Constitutions address broad principles of government. They are vehicle by which reasonable people govern themselves. They exist to protect minority and major ity rights. They exist to preve the tyranny of the majority by providing systems of checks and balances. Constitutional democracy is our most valued public possession. Our constitution should be honored because it speaks for all people and not for one special interest group against another. Should a constitution address the governor's salary, legislative or judicial compensation, attorneys' fees, doctors' fees, or any public servants' pay? Shall we lose our ability to govern expeditiously and reasonably? Is the liability crisis so bad as to surrender our heritage of constitutional government? Emphatically, NO Contingency fee arrangements if they are inappropriate, are worthy of legislative and/or ju dicial reform, but they are inappropriate in a cherished document.

Let us not slight our valued principles for an attractive expediency. It is but one alluring siren that waits to sink us on the rocks of despair. There is much to be done by all other legal means. Let us not be steered away from an orderly and appropriate course.

Gerald H. Mandell, M
Detroi

By Louis R. Zako, MD

What next?

With the recent passage of tort reform legisla- on, those of us who have ved and breathed the mal- ractice crisis have time to riefly reflect upon the sig- ificance of past events and to sk, "what next?"

Clearly, what has and has ot happened over the past 18 ionths to two years presents a iixed picture of modest ac- omplishments and deep and obering disappointments. The)ctober rally in Lansing has hanged the political land- cape in Michigan for a long ime to come. It arguably npressed politicians and the eneral public. (One might add arenthetically that politicians re more impressed by their e-elections and by those who elp in their re-elections than y rallies.) But what it did o the general public is far nore significant. You and I, ow numbering in the thousands, now know how difficult it is to change the system, but more importantly, we know now much better how to go about it.

There is general agreement that the tort reform package passed was at best a modest package. Each and every one of the bills passed should help, but how much? No one really knows, and many of us suspect not nearly enough. Some have argued that we should have publically rejected the entire compromise package, a point of view which I respect but do not share. To me modest reform (some relief) is better than no reform (no relief).

Without a doubt, the major disappointments we have sustained for all of our efforts have been the failure to obtain the necessary 304,000 petition signatures to allow the people of Michigan to decide this November if they wish to limit the contingency fee and the lack of a meaningful cap on non-economic damages, and a meaningful reduction in the statute of limitations for minors in the legislation passed.

Where do we go?

Where do we go from here? It seems that each individual physician has several choices. One such choice, certainly the most painful and difficult for most of us, is to close our practices and move to another state or earn a living by other than clinical practice. I personally know of several physicians who left the state last year or this year because of the malpractice crisis and many more who are seriously considering such an option. I also know a middle-aged orthopedic surgeon who closed his practice last year and is now in law school. Further, it seems that more obstetricians now work for Blue Cross Blue Shield of Michigan than deliver babies.

Another option, historically a popular one, is to bitch, bemoan one's sad plight, and blame others for failing to solve our problems. It is interesting to note that there are approximately 11,000 members of MSMS and that between 300 and 500 of us regularly obtained petition signatures in our offices, totaling 200,000 signatures. One might speculate and calculate what would have happened to the petition drive if 5,000 or 10,000 physicians actively solicited signatures.

Still a third option, one to which I personally subscribe, is to accept this malpractice crisis as a national crisis of overwhelming proportion for which there are no easy answers, and to attempt to do whatever needs to be done, for as long as it needs to be done, to resolve the crisis. Colleagues, in case you have either not been sued recently or received a premium notice recently, let me inform you we are at war! Winning or losing a battle is

Continued on next page

)octor Zako is a Dearborn Heights amily physician.

not winning or losing a war. The war will be won by those who have the necessary resources to win: motivation, skill, money, self-discipline and staying power.Permit me to break option three down into an action plan:

1. Continue to gather petition signatures over the next three months, another 200,000 signatures, to permit the contingency fee limitation question to appear on the ballot in November, 1988. Too far away, you say? Would you rather limit the contingency fee in 1988 or in 2020? Further, have you thought of the psychological effect on the politicians of this state in the spring of 1987 when they know 400,000 registered voters are interested in looking at the obscenity known as the contingency fee?

2. Be personally involved in the political campaign of one individual running for governor, state senator, state representative, judge or supreme court justice.

3. Vote! Vote knowledgeably — is the candidate a friend of medicine or not? Get family members to vote. Be sure you are registered to vote. Do not hesitate to request an absentee ballot if you might be tied up all day at the hospital with a delivery. Recommend friends of medicine to your patients so that your vote will become a hundred votes. See a psychiatrist if you have this paranoid idea that your practice should not be politicized. If you cannot afford a psychiatrist, read my book on how a malpractice suit politicizes a practice.

4. Support MSMS efforts to obtain a shortened statute of limitations, a meaningful cap on pain and suffering, and a counter-suit bill in the next legislative session.

5. Support in concept the idea of a cap on all awards linked to some sort of state reinsurance fund and provide us with your ideas on how this should be structured so that it helps rather than hurts.

6. Support long-range efforts to eliminate tort law as the way to care for those who are seriously injured in the course of medical treatment. Tort law has patently helped improve the quality of life for plaintiffs' attorneys, but what has it done for patients? Tort law has unquestionably made life more pleasant for the families of a few hundred children who have sustained or have alleged to have sustained serious vaccine injury, but what has it done to insure the supply or the affordable cost of vaccines?

7. Recognize that there are bad doctors, not many, but some. Every bad doctor is the enemy of the good doctor. Those few who operate while drunk, who sell narcotics for personal gain, who are paranoid schizophrenics and who hear voices while treating patients, and those who sexually assault their patients are a danger to us all, public and profession. Tort law and plaintiffs' attorneys have not and never will be able to protect us from them. Support legislation which fosters effective peer review and appropriate Board of Medicine oversight.

Finally, consider what you may have been unreasonably afraid to consider. Your fees. Let me be the first to admit that I find it impossible to help an individual obstetrician deal with the malpractice crisis when he or she, out of fear, accepts a reimbursement of $700 or $800 for total obstetrical care while paying malpractice premiums of $70,000 or $80,000 a year, or a pediatrician who charges less for a polio vaccine than he or she pays for it. Am I mistaken, or is participation/acceptance of assignment in Medicare, Blue Cross, Medicaid, HMOs, PPOs in Michigan still optional? If Chrysler Corporation wishe you to provide medical care its not impoverished employees at a discount throug Blue Cross participation or HMO/PPO involvement, woul it not be reasonable to ask Chrysler Corporation first to strongly support meaningful tort reform; secondly, accept mandatory arbitration clause for malpractice disputes in its HMO/PPO contracts; thirdly, offer discounts on its cars to physicians; and lastly, start speaking out on what is signi cantly contributing to health care cost escalation rather than just criticizing this escala tion?

If you undervalue your own worth, I or other MSMS leade cannot help you. We are sympathetic, but we cannot tell you that you are doing the right thing by charging less fo your professional services tha the cost of delivering that service. The next time a third party asks you to sign up for their plan, ask yourself if they are in such dire financial strait that you should subsidize thei health care contracts as an ac of charity.

I would be pleased to receive your comments, suggestions, and constructive crit cism at MSMS, Box 950, East Lansing, Michigan 48823. Please request petition blanks and send contributions to Citizens Liability Action Committee, Suite G-20, Atrium Building, 3351 Claystone, SE, Grand Rapids, Michigan 48506. Send $150 noncorporate checks for sustainin membership in MDPAC (Michigan Doctors Political Action Committee) to Box 759, East Lansing, Michigan 48823. Sen recriminations and complaints to Box Round File, East Lansing, Michigan 48823.☐

By Richard D. Weber

Legal counsel discusses further tort reform

MSMS will continue its legislative attempts at further tort reform this fall. Efforts will be made to further restrict the statute of limitations applicable to minors and to eliminate the broad exceptions to e limitation on non-economic damages. Statutes covering these and other multiple tort reforms were cently enacted. In addition, MSMS will seek legislation expanding arbitration and enabling physician ountersuits. The following article prepared by MSMS legal counsel, Richard D. Weber, discusses these two ecific tort reform proposals.

panded use of arbitration

The Michigan Medical Ar- tration Act (MMAA) (MCLA 00.5040 et seq.) has not chieved the level of use origi- ally intended when the legis- tion was passed in 1975. tringent recovation rights ontained in the Act, and mul- ple adverse litigation preced- g the Michigan Supreme ourt's favorable ruling in *orris* v *Metriyakool*, 418 ich 423 (1984) are the rimary reasons.

New medical delivery struc- ures and reimbursement tech- iques not in existence when e MMAA was passed provide parallel framework with hich to coordinate more use- l and meaningful arbitration f malpractice disputes. En- bling legislation to support such a broader arbitration policy is necessary. Such legislation would be comprehensive in its effort to allow and promote the private arbitration of medical malpractice cases in virtually all private health care plans.

The arbitration agreement would be imposed in the finance setting rather than in the medical treatment setting. That is, the agreement would be effected prior to the fact of treatment and arise out of the relationship between the insurer and insured or employer and employee, rather than the physician—patient relationship. Moreover, such enabling legislation would seek to avoid the opt-out provisions, which have rendered ineffective much of the current MMAA. The arbitration agreement would not be required to be signed each time care is sought; the initial agreement to the arbitration program in the health care financing mechanism would be sufficient. Once the agreement is established, adjudicative procedures similar to the MMAA would become applicable. This would include the right to counsel, written record, impartial panel, flexible remedies and administrative assistance through the same processes as the MMAA in coordination with the American Arbitration Association.

The enabling legislation would be in addition to and not in place of the MMAA. Benefit plan pricing, co-pays and deductibles could reflect choice of arbitration alternatives. Consumers could be given an economic incentive to choose arbitration.

The legal justification for such a system would be, generally speaking, that the arbitration feature is one of the bargained for or perhaps even optional features of the private contracting process. Coupled with adequate consideration and notice to consumers, this would arguably justify sustaining waiver of a jury trial in any malpractice dispute which arises out of the provision for benefits.

No legal precedent exists in Michigan. California courts have upheld arbitration clauses in collectively bargained agreements, *Madden* v *Kaiser Foundation Hospitals*, 17 Cal 3d 699 (1976), and through enrollment benefit contracts in which an individual voluntarily

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r. Weber is a partner with Kerr, ussell and Weber, MSMS legal ounsel, Detroit.

FURTHER REFORM/Continued

enrolled through her employer, *Wilson* v *Kaiser Foundation Hospitals*, 141 Cal App 3d 891 (1983). The choice of a common bargaining agent of at least comparable if not equal bargaining power to that of the health benefit plan was the central rationale for upholding the collectively bargained arbitration clause. In the individual case, the choice of participation in the employer provided plan by the employee was sufficient. Although California law is not Michigan law, it is supportive, albeit nonbinding precedent.

MSMS legal counsel has drafted detailed legislation to support expanded use of arbitration. MSMS plans to pursue such legislation at the next legislative session.

Countersuit legislation

MSMS has proposed legislation authorizing countersuits for wrongful medical malpractice actions. This bill is designed to overcome the insurmountable barriers established by the Michigan Supreme Court in *Friedman* v *Dozorc*, 412 Mich 1 (1981). In *Friedman*, the Supreme Court held that a lawyer's duty is solely to his client, and therefore cannot be liable for the tort of negligence to anyone other than his client.

The Supreme Court did hold that a countersuit by a physician against a lawyer could be premised upon the torts of abuse of process or malicious prosecution. Unfortunately, such remedies are virtually meaningless. To recover for abuse of process, the plaintiff must prove an ulterior purpose and an act in the use of process which is improper in the regular prosecution of the proceedings. To recover under the theory of malicious prosecution, the counterplaintiff must establish that the malicious prosecution action was terminated in his favor, that the plaintiff did not have probable cause, acted with malice and the defendant physician sustained "special damages." Special damages are defined as physical arrest, such as loss of personal liberty or seizure of property. These kinds of damages never occur in medical malpractice action. Moreover, malice requires proof that the primary purpose of the malpractice action was other than that of securing a proper adjudication of the claim. A detailed discussion of the torts of abuse of process and malicious prosecution is not within the purview of this article. Suffice it to say, neither tort presents a meaningful remedy for a physician's countersuit.

The bill proposed by MSMS would allow a civic cause of action for damages to be filed by the physician against the person who commenced the medical malpractice action and/or the attorney who represented such person if th following circumstances exist

- The proceeding was termina ed in favor of the defendant physician.
- The physician suffered injur or damage as a result of the malpractice action, with the proviso that special damages need not be established.
- The person who commence such action and/or the attorn did not have a good faith belief, based upon reasonabl investigation, in the existenc of the facts upon which such action was based and/or did not have a good faith belief, based upon reasonable inquir that such facts constituted a valid claim under existing law or a good faith argument for the extension, modification o reversal of existing law.

The key to this legislation i the objective criteria require to determine whether a "goo faith belief" existed. With respect to the underlying malpractice facts and law, "reasonable investigation" and "reasonable inquiry" objectiv standards are established. Th focus under the bill is not limited to the subjective inter of the malpractice plaintiff or attorney.

Moreover, damages would not be limited to the costs an attorney fees. All civil damages available to plaintiff under the existing tort law would be available to the countersuing physician.☐

Liability task force hears nterpretation of new laws

The MSMS Task Force on Professional Liability, chaired by Louis R. Zako, MD, heard Richard Weber, MSMS legal counsel, Detroit, explain in detail legislation signed into law last month. MSMS President-elect Carl A. Gagliardi, MD, is pictured introducing Weber. The June 4 working session was when task force members identified six major actions MSMS will take in further reform efforts. (Those actions were first reported in the June 12 *Medigram*, and continue to be detailed in current issues.)

ISMS President Thomas R. Berg-
ind, MD, an advisor to the task
orce, carefully read the wording
f the liability legislation. Task
orce members are: Louis Zako,
ID, chairman; Cathy Blight, MD;
Irs. Lois Duhamel; Richard Gas-
oigne, MD; D. Bonta Hiscoe, MD;
homas Kwyer, MD; Robert
eitch, MD; W. Peter McCabe,
ID; Frederick Minkow, MD;
homas Payne, MD; Rhoda
owsner, MD; James Read, MD;
Iitchell Rinek, MD; John Shek,
ID, and Charles Vincent, MD.

Liability lawmakers detail negotiation process

By Rep. Lewis N. Dodak

After almost one year of intensive work, the House and Senate reached final agreement in mid-June on a seven bill package that was sent to the governor for signature. That package of legislation represents the most comprehensive law reform project the Legislature has undertaken in my 10 years in the Michigan House of Representatives.

While no single party or interest group is fully satisfied with the outcome of our deliberations, I believe that the package represents a "reasonable compromise" to a very difficult and emotional problem. Building on the work of both the Senate Select Committee on Civil Justice Reform and the House Special Committee on Liability Insurance we were able to go beyond discussions which focused on tort reform only in the areas of governmental immunity, dram shop and medical malpractice to look at comprehensive reform of the manner in which personal injury lawsuits of all types are litigated in Michiga Additionally, taking the lead the House, we were also able to focus attention on the insu ance industry as well as on th medical licensure board.

Having served as the Chair of the House Special Committee, I was asked by Speaker Owen to serve as a member c most of the conference committees and to serve as Chair of the Conference Committee on HB 5154. Because the outcome of that Committee's deliberations were key to

Rep. Lewis Dodak (D-Montrose), left, and Sen. Daniel DeGrow (R-Port Huron) were co-chairmen of the House/Senate conference committee on liability reform.

By Sen. Dan L. DeGrow

Because of the role I played in negotiating the final agreement on the civil justice reform package, I appreciate the opportunity to express my views regarding this critical legislation.

First, some general impressions regarding the reforms. Most importantly, I am confident that this legislation represents real and substantial progress in resolving the medical malpractice crisis. In all the key areas—the cap on noneconomic damages, statute of limitations, mediation, and frivolous lawsuits—we have achieved significant, balanced reforms.

However, I recognize, as you recognize, that further reform is clearly necessary. This is especially true in the areas of the cap on noneconomic damages and statute of limitations.

The reforms with respect to medical malpractice are extensive. There are several provisions new to the law that I believe will have a positive im pact on the medical malpractice problem. These include mandatory mediation, affidavi of noninvolvement, affidavit c merit, limits on expert witnesses, and the cap on noneconomic damages.

Mediation is required, and the panel will include two health care providers. The panel will be required to make a specific finding regarding th standard of care. The affidavit of noninvolvement allows a health care provider to motion the court for dismissal of the action because of noninvolvement. The action shall be dismissed unless the plaintiff objects. The affidavit of merit requires the plaintiff to file either a written opinion that the case has merit or post a bond of $2,000. The limits on expert witnesses requires ex-

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Sen. DeGrow (R-Port Huron) and Rep. Dodak (D-Montrose) were co-chairmen of the House/Senate conference committee on liability reform.

aching agreement on the tol package, Senator DeGrow d I were under even greater essure to find a basis for reement as quickly as possile. To this end, we worked to ach agreement on the major oncepts while understanding at much of the detail of the ll would have to be negotied when staff prepared the nguage for the Conferees to gn.

The negotiation process we nployed was somewhat fferent from the normal ourse during conference comittees. Specifically, Senator eGrow and I met for many ours during which each of us fered various compromise oposals. No final agreement as reached on any major oint, however, until we were epared to agree on all of em as a package. This meant at while we discussed possie compromises on joint and everal liability, the statute of nitations, elimination of ejudgment interest, the colteral source rule and the cap, until there was a basis for agreement on all of these issues, neither one of us signed off on any of them.

Once the agreement in principal was reached, we still continued to meet because of the need to work out the details of the language. Interestingly enough, it was at this point that some of the simpler issues to resolve in principal, e.g. structured payments, became the most difficult to reach agreement on in terms of language.

At each stage of the agreement, Senator DeGrow and I met with our respective conferees to review the agreements and the language before they were made public. Although the process took us somewhat longer than anticipated to complete, it is my belief that the end product represents a major step forward in our effort to provide meaningful reform.

As I noted at the outset, there is no interest group that is completely satisfied with the agreement; thus, it is my expectation that there will continue to be pressure for additional changes in the system. Before making a commitment to support any specific additional reforms, it is my intention to have the Special House Fact-Finding Committee that I chair hold a series of public hearings this summer to take testimony on both the financial condition of the liability insurance industry in Michigan and the impact of the recently enacted reforms on the industry. Additionally, the Committee has agreed to engage the services of a consultant to assist us in this process which we hope to have completed prior to the beginning of the fall session.

By taking the time to thoroughly evaluate the immediate as well as potential impact of the reforms already enacted, it is my hope that future deliberations, as I am sure there will be, can be even more effective than those of the past year.☐

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erts to spend a substantial ortion of practice or teaching the same area of specialty f the defendant. The cap proides for a $225,000 limit on oneconomic damages, with everal exceptions. These reorms are new and provide the otential, with future refineents, for resolving the medial malpractice problem.

In addition to these new reorms, the statute of limitaons for minors is reduced om 19 years of age to 15 ears of age. A six-year statute f repose is placed on the disovery rule, subject to several xceptions. This begins to adress the "long tail" problem at greatly increases premims for medical malpractice surance.

From a regulatory standoint, the licensing boards for ealth care providers have reatly increased powers to attack the problem of "bad doctors." This is very important because a small number of doctors commit a substantial portion of all malpractice. Also, criminal penalties are provided for the fraudulent alteration or destruction of medical records.

Other general tort reforms will impact on medical malpractice litigation. The reforms to prejudgment interest, the collateral source rule, and structured payments should ease the escalation of medical malpractice premiums by directly decreasing judgment awards.

These reforms that I have described were achieved in the context of an extremely complex and diverse legislative package that involved not only medical malpractice, but dram shop liability, governmental liability and general tort reform. In addition, it is clear that the House of Representatives was unwilling to support the extensive reforms strenuously advocated by the Senate. The resulting reforms then necessarily involved compromise with the House of Representatives and the interests of the other industries, groups, and governments impacted by the liability crisis.

To conclude, I am proud, and the Senate Republicans are proud, to have provided the leadership that led to the enactment of these reforms. At the same time, we have affirmed our resolve to provide the leadership in the future to complete the reforms necessary to solve the medical malpractice crisis.☐

Why not arbitrate?

By Rhoda M. Powsner, MD an
Frances Hamermesh

Reprinted with permission from the June, 1986 issue of the Washtenaw County Medical Society *Bulletin*.

For the second time in a decade, the Michigan Legislature is attempting to resolve the medical malpractice "crisis." In the process of resolving a similar "crisis" in 1975, it passed the Michigan Medical Malpractice Arbitration Statutes, which permit voluntary binding arbitration of disputes involving medical care.

The empirical evidence gained from the Michigan experience with medical malpractice arbitration demonstrates the practical advantages and appropriateness of arbitration as an alternative to the courts in the malpractice arena, and suggests that the legislature's present efforts should emphasize arbitration and include modifications which rectify problems identified in the 1975 statutes.

The Michigan Medical Arbitration Statutes

The Michigan Medical Malpractice Arbitration Program was enacted as part of the total 1975 medical malpractice package through amendments to existing legislation. The key amendment to the insurance code requires all companies selling professional liability insurance to hospitals to ensure, as a condition of doing business in the state, that their insureds offer the arbitration option to patients. Other amendments to the code specified that the Michigan Arbitration Act was binding on all hospital employees and set a required level of independent practitioner participation. In addition, an advisory committee to the insurance commissioner and an Arbitration Administration Fund were created with the provision that the insurance commissioner, in consultation with the advisory committee, develop rules and forms for the implementation of the program.

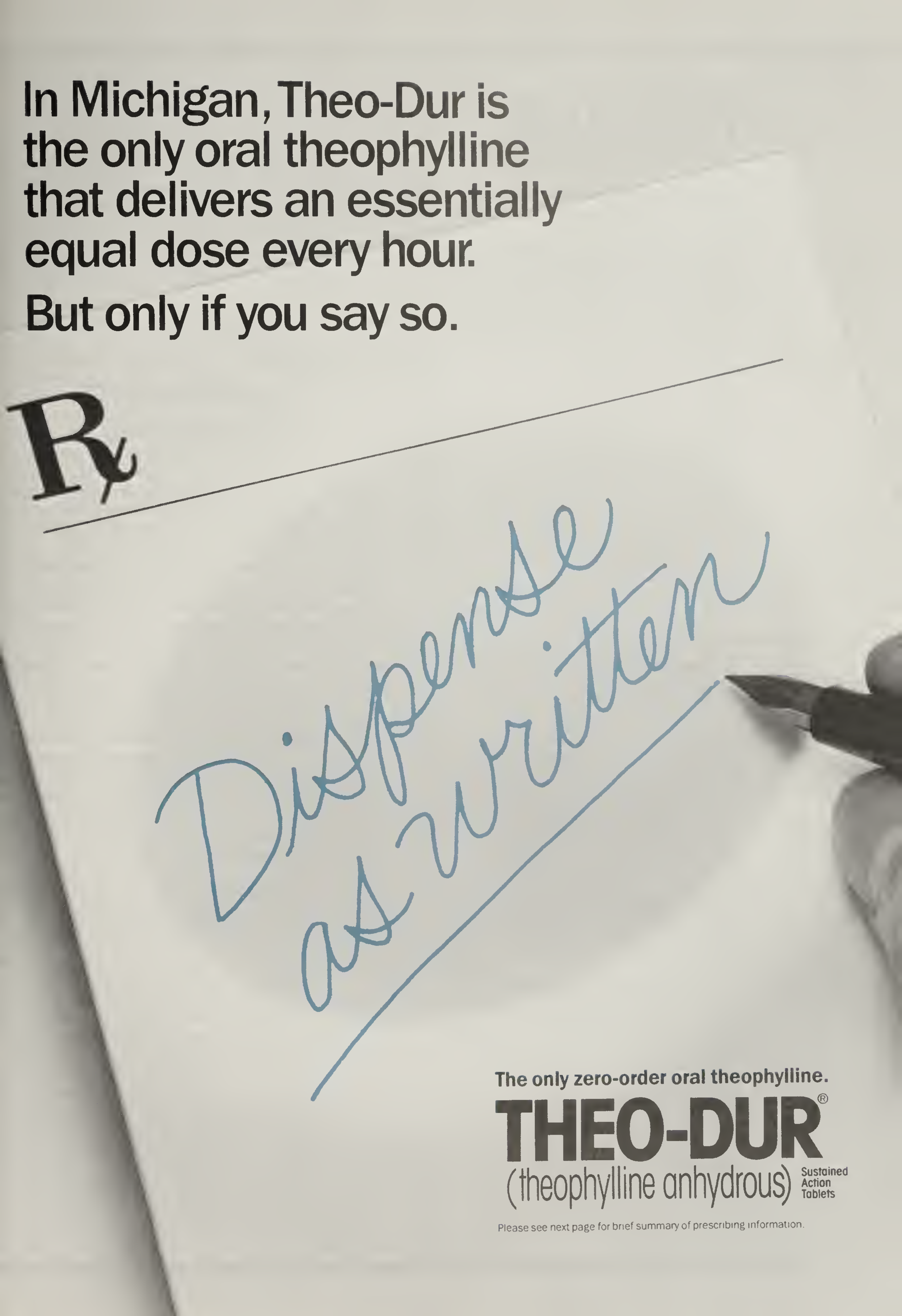
A companion bill, which amended the general arbitration statute, contained the provisions governing the medical malpractice arbitration process. Health care providers, hospitals or their agents are liable for injury or death caused by "error, omission, or negligence in the performance of professional services . . ." and/or for "performance of such services without consent, in breath of warranty or violation of contract." To assure voluntary patient participation the arbitration agreement must state that signing of the agreement is "not a prerequisite to care:" The patient or his legal representative may revoke the agreement within 60 days after discharge. The agreement for hospital care is valid for each individual contact unless there is continuing treatment on a long-term outpatient basis, in which case a signed agreement will expire at the end of one year. Offerers must not only explain the agreement completely prior to signature, but must also provide the patient with an informational booklet. The agreement cannot be offered to a patient in the emergency room until the completion of treatment.

The 1975 Medical Malpractice Arbitration Statutes possess the salient features of arbitration. There is provision for an independent third-party decision maker. The award is on the merits and is not intended to be a compromise: the decision is final and binding. However, while participation is voluntary for patients, offering by the hospitals whic are covered under their provision is mandatory. The rule-based nature of the system affords some predictability, but decisions are not precedent setting because of the private nature of the process and restrictions on dissemination of information about the awards.

On March 1, 1984 the Michi gan Supreme Court upheld the constitutionality of the Michigan Arbitration Program, and resolved both the constitutional and contractual issues in its favor. The Court considered two cases: *Morris v. Matriyakool*, in which the Court of Appeals had upheld the validity of the arbitration statute, and *Jackson v. Detroit Memorial Hospital* in which the court of appeals had found it to be unconstitutional. The Supreme Court held that the composition of the panel with its health care provider does not violate due process since the plaintiffs had not demonstrate a pecuniary interest that "creates a probability of unfairness." The Court also found that "The burden of avoiding these arbitration agreements . . . rests with those who would avoid them." The act states that an agreement to arbitrate which includes the statutory provisions shall be "presumed valid." Moreover, the court noted that the agreement to arbitrate is not a contract of adhesion or an unconscionable waiver of the right to a jury trial.

Continued on page 41

Doctor Powsner is a member of the Arbitration Advisory Committee to the Insurance Commissioner. Frances Hamermesh is currently a student at the University of Michigan Law School.



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Warnings: Excessive theophylline doses may be associated with toxicity; serum theophylline levels should be monitored to insure maximum benefit with minimum risk. Incidence of toxicity increases at serum levels greater than 20 mcg/ml. High blood levels of theophylline resulting from conventional doses are correlated with clinical manifestation of toxicity in: patients with lowered body plasma clearances, patients with liver dysfunction or chronic obstructive lung disease, and patients who are older than 55 years of age, particularly males. There are often no early signs of less serious theophylline toxicity such as nausea and restlessness, which may occur in up to 50% of patients prior to onset of convulsions. Ventricular arrhythmias or seizures may be the first signs of toxicity. Many patients who have higher theophylline levels exhibit tachycardia. Theophylline products may worsen pre-existing arrhythmias.
Precautions: THEO-DUR TABLETS SHOULD NOT BE CHEWED OR CRUSHED. Theophylline should not be administered concurrently with other xanthine medications. Use with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, in the elderly (especially males) and in neonates. In particular, great caution should be used in giving theophylline to patients with congestive heart failure. Frequently, such patients have markedly prolonged theophylline serum levels with theophylline persisting in serum for long periods following discontinuation of the drug. Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to the G.I. tract although gastrointestinal symptoms are more commonly centrally mediated and associated with serum drug concentrations over 20 mcg/ml.
Individuals who are rapid metabolizers of theophylline, such as the young, smokers, and some non-smoking adults, may not be suitable candidates for once-daily dosing. These individuals will generally need to be dosed at 12 hourly or sometimes 8 hourly intervals. Such patients may exhibit symptoms of bronchospasm near the end of a dosing interval, or may have wider peak-to-trough differences than desired.
Usage in Pregnancy: Animal reproduction studies have not been conducted with theophylline. It is not known whether theophylline can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Xanthines should be given to a pregnant woman only if clearly needed.
Nursing Mothers: It has been reported that theophylline distributes readily into breast milk and may cause adverse effects in the infant. Caution must be used if prescribing xanthines to a mother who is nursing, taking into account the risk-benefit of this therapy.
Pediatric Use: Safety and effectiveness of THEO-DUR administered every 24 hours in children under 12 years of age, and every 12 hours in children under 6 years of age, have not been established.
Adverse Reactions: The most consistent adverse reactions are usually due to overdose and are:

Gastrointestinal: nausea, vomiting, epigastric pain, hematemesis, diarrhea.

Central nervous system: headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions.

Cardiovascular: palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias.

Respiratory: tachypnea.

Renal: albuminuria, increased excretion of renal tubular and red blood cells, potentiation of diuresis.

Others: rash, hyperglycemia and inappropriate ADH syndrome.
How Supplied: THEO-DUR 100 mg, 200 mg and 300 mg sustained action tablets are available in bottles of 100, 500, 1000 and 5000, and in unit dose packages of 100.
Caution: Federal law prohibits dispensing without prescription. For full prescribing information, see package insert.

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ow the Michigan rbitration Program functioning

How, then is arbitration func- oning as a process for adjudi- tion of medical malpractice sputes in Michigan?

The following tabulation of tivity over the ten years the ogram has been in existence veals that arbitration has not en widely adopted for the solution of medical malprac- ce disputes. The total of 600 lings with arbitration is small comparison with the total umber of claims that have en filed during the same eriod of time; however, ex- mination of awards and data hich indicates the lessened me and cost required for aching a decision suggests at arbitration is a fair and ost effective method of dis- ute resolution. Now that the onstitutional and contractual sues have been resolved in ichigan, two questions re- ain: Is arbitration a desirable lternative to the courts for e resolution of medical mal- ractice disputes? If it is, then ow can it be made attractive those seeking to resolve uch disputes?

tatistics

Since the filing of the first ase with the American Ar- itration Association in ovember, 1976 up to March 1, 1986, 600 demands for ar- itration have been made. Of ose, 502 have been closed nd 97 are pending. Of those losed, 94 have been with- rawn, 210 were settled, 69 ere closed administratively, nd 131 were decided by ar- itration panels.[*] Three-fourths f the decisions favored the espondents.

The mean award of the 33 cases found in favor of claimants was $50,120; with the extremes omitted, the mean award in 31 cases was $40,449.

The 210 settled cases range from $363 to $15,000,000, the latter in a structured award. The mean settlement with extremes omitted was $23,624.

Administrative closings of 69 cases were primarily based upon inactivity. These cases may be reopened upon request.

In cases which have been determined by arbitrators, the average length of hearings has been 2.0 days, and the cost of the proceedings, including arbitrators' fees and expenses, administrative expenses, and electronic recordings of proceedings has averaged $1,499 per case.

The average time elapsed at the various states of arbitration are as follows: from date of filing to award: approximately 22 months; from date of filing to settlement: approximately 18.7 months; from date of filing to withdrawal: approximately 13.4 months.

The awards

The Michigan Medical Malpractice Arbitration Act provides that the arbitration panel "shall render a written opinion which states its reasoning for the finding of liability of nonliability, and the reasoning for the amount and the kind of award, if any." The statute also permits a written dissent. However, one of the hallmarks of arbitrations administered by the AAA is privacy. Although legislation does require notice of filing of claims and transmittal of awards to the Michigan Insurance Bureau and relevant licensing boards, nevertheless, the process by which a decision is reached and the grounds for that decision are essentially not open to inspection.

In view of this, we believed it was necessary to review the opinions in order to understand the manner in which adjudication took place in the Michigan Arbitration Program and to evaluate arbitration's effectiveness as an alternative to the courts in resolving malpractice disputes. The Detroit Regional Office of the AAA permitted us to examine 91 of the 106 panel awards which had been made by June of 1985.

Of those cases reviewed, 10 were filed *in propria person*. Claimants named allopathic physicians and hospitals in equal numbers, but only one fifth as many osteopathic as allopathic physicians were named. At least one nurse and one dentist were among the respondents. Claimants included husbands and wives jointly as well as parents or guardians who had signed arbitration agreements for minor children.

The Arbitration model and the awards

The third party decision-maker

Arbitration requires adjudication by a third party who is independent of the dispute, free from bias, able to make a decision on the merits, and, often, has expertise on the matter in dispute.

Critics of the MMMAA have focused on the issue of bias of the panel as a major concern. The make-up of the panel with its physician member was one of the most frequently cited arguments in legal challenges contesting the validity of the arbitration agreement. The Michigan Supreme Court resolved the issue in favor of the statutory provision.

On review of the awards, the authors found that panel decisions were unanimous in all but two instances. Such agreement among the panel members argues well for the independence of the panel. The nature of the rulings and the number and

Continued on page 412

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[*] The total number of cases for which ispensations are noted exceeds that f the number filed. This is due to arlier record-keeping by the American rbitration Association, which did not eparate out administratively-closed ases which were subsequently eactivated.

variety of panelists to date suggests that the medical members have not unduly influenced the determinations.

The tripartite panel in arbitration of medical malpractice disputes permits the use of particular expertise and skills. In their respective roles, the medical and legal panelists do not replace the expert witness or judge, but rather, serve to interpret and aid the other panelists in understanding technical matters. That the panel opinions have so often noted the failure to prove, or have questioned the sufficiency of the proof of the breach of the standard of care, indicates that the health-provider panelist has not replaced the expert witness.

Decision on the merits

One feature that distinguishes arbitration from mediation is that a mediated decision is the result of negotiation and compromise, while an arbitrated decision is on the merits. As brief as they are, panel opinions demonstrate respect for the arguments presented by each party and it is apparent that extreme care is taken to provide an opportunity for the parties to present evidence that will clarify the issues in dispute. In two cases, in which the claimants were denied awards, the panel expressed concern about the adequacy of hospital records and apparently as a consequence, assessed costs against the respondents.

When claimants have not been represented by counsel, panel opinions reflect diligence in assessing whether the claimant has submitted evidence sufficient to carry his or her own burden of proof.

Rules applied

The Michigan arbitration opinions reveal that the panelists' evaluation of evidence has been consistent with state tort and medical malpractice law. The issues which have been encountered with the greatest frequency involve the standard of care and informed consent, rather than the statute of limitations and the doctrine of *res ipsa loquitur*, both of which have been more prevalent in some studies of court adjudication.

The ability of the claimant to demonstrate a breach in the standard of care has been the single most important finding in panel opinions. This was cited as the deciding factor in 42 percent of the cases. In four percent of cases the panel denied claims explicitly because of the claimant's failure to provide expert testimony. This particular finding makes clear the need to instruct the arbitrators about MMMAA rules which do not require expert testimony. Of interest is the fact that very few opinions reflected the need to weigh contradictory evidence.

Other issues which have appeared in panel opinions include: informed consent, breach of warranty, the statute of limitations, and the existence of a valid arbitration agreement. In four cases the panel considered the degree of fault of the parties and issued an award based on comparative negligence. In two cases in which the respondent had admitted liability, the panel had only to decide the value of the award. Immunity of a governmental institution, failure to establish an injury, and failure to comply with the requirements of the arbitration proceeding are the basis for denial in one case each. There were three opinions which noted that the claimant was not represented by counsel: in all three instances the claims were denied.

The informality of the medical malpractice arbitration has permitted results that would not be as likely in litigation. One panel found that the claimant failed to establish negligence, but found it equitable for the surgeon to return one half of a $250 surgical fee.

Pace of litigation

The length of time before a dispute is resolved has been a great matter of concern in medical malpractice cases. Insurers and health care providers have sought changes in the statutes of limitations to limit the unpredictable impact of cases brought many years after the incident. Among the benefits of arbitration is that is does not need to contend for a place on a crowded court docket, thus a reduction in the length of time from filing to completion can be anticipated.

Despite the many delays occasioned by the legal challenges arbitration has proved to resolve disputes somewhat faster than the court system. A study of the Michigan Arbitration Program overall demonstrates that arbitrated cases took four months less from filing to closing than court cases. This shorter time has proved fairly constant from year to year over a ten-year period; however, it is pertinent to this discussion to note that data just developed by the AAA indicates that for the 184 cases filed since the March 1, 1984 Supreme Court decision, the average arbitration hearing length has decreased to 1.5 days and the average cost per hearing has dropped from $1,499 per case to $1,093. The average time elapsed from time of filing to the award is now approximately 13.6 months; from date filing to settlement is 9.2 months; from date of filing to withdrawal is 8.8 months. It appears that the problem of delays may be abating.

Delays in both arbitration and the courts have been related to insurance industry discouragement of speedy settlement, lack of attorney preparation, payment of defense attorneys on an hourly

Continued on page 419

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Once-daily dosing may enhance compliance in patients for whom dosing convenience is important

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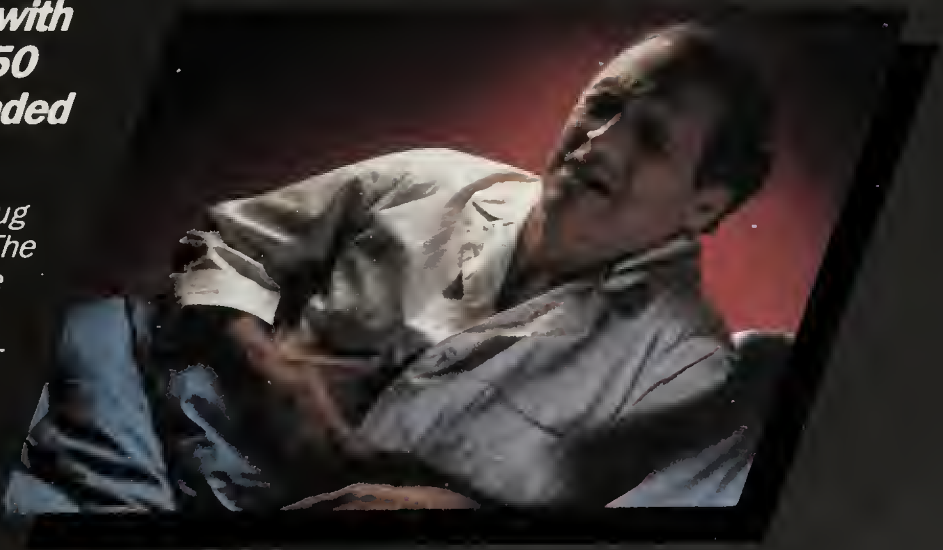
Headache—sometimes severe—has been reported. Rare effects on the CNS, cardiovascular, GI, hepatic, and integumental systems have been observed, as well as rare cases of hypersensitivity reactions. See ADVERSE REACTIONS section of Brief Summary of Product Information before prescribing.

No significant interference with the hepatic cytochrome P-450 enzyme system at recommended doses

ZANTAC 300 mg h.s. had no significant drug interactions with theophylline or warfarin. The bioavailability of certain medications whose bsorption is dependent on a low gastric pH ay be altered when ZANTAC or other medica- ns which decrease gastric acidity are ministered.



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See next page for references and Brief Summary of Product Information.

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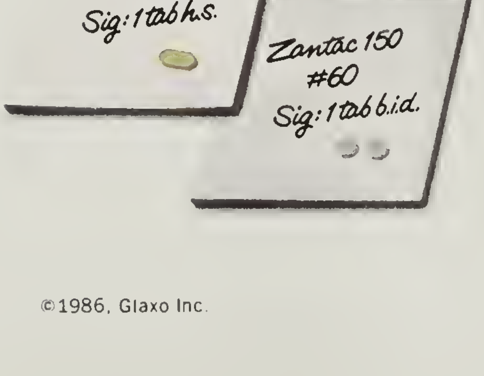

References: 1. Data available on request, Glaxo Inc. **2.** Ireland A, Colin-Jones DG, Gear P, et al: Ranitidine 150 mg twice daily vs 300 mg nightly in treatment of duodenal ulcers. *Lancet* 1984;2:274-275. **3.** Colin-Jones DG, Ireland A, Gear P, et al: Reducing overnight secretion of acid to heal duodenal ulcers. *Am J Med* 1984; 77 (suppl 5B):116-122.

ZANTAC® 150 Tablets
(ranitidine hydrochloride)
ZANTAC® 300 Tablets
(ranitidine hydrochloride)

BRIEF SUMMARY OF PRODUCT INFORMATION

INDICATIONS AND USAGE: ZANTAC® is indicated in:
1. Short-term treatment of active duodenal ulcer. Most patients heal within four weeks. Studies available to date have not assessed the safety of ranitidine in uncomplicated duodenal ulcer for periods of more than eight weeks.
2. Maintenance therapy for duodenal ulcer patients at reduced dosage after healing of acute ulcers. No placebo-controlled comparative studies have been carried out for periods of longer than one year.
3. The treatment of pathological hypersecretory conditions (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of active, benign gastric ulcer. Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated. Studies available to date have not assessed the safety of ranitidine in uncomplicated, benign gastric ulcer for periods of more than six weeks.
5. Treatment of gastroesophageal reflux disease. Symptomatic relief commonly occurs within one or two weeks after starting therapy. Therapy for longer than six weeks has not been studied.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: ZANTAC® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: General: 1. Symptomatic response to ZANTAC® therapy does not preclude the presence of gastric malignancy.
2. Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see **DOSAGE AND ADMINISTRATION**). Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during ZANTAC therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although ZANTAC has been reported to bind weakly to cytochrome P-450 in vitro, recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at doses up to 2,000 mg/kg/day.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, E coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next nine weeks.

Pregnancy: ***Teratogenic Effects: Pregnancy Category B:*** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ZANTAC. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: ZANTAC is secreted in human milk. Caution should be exercised when ZANTAC is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients (82 years of age) were no different from those in younger age gr The incidence rates for adverse events and laboratory abnorm were also not different from those seen in other age groups.

ADVERSE REACTIONS: The following have been reported as eve clinical trials or in the routine management of patients treate oral ZANTAC®. The relationship to ZANTAC therapy has unclear in many cases. Headache, sometimes severe, seems related to ZANTAC administration.

Central Nervous System: Rarely, malaise, dizziness, somnol insomnia, and vertigo. Rare cases of reversible mental conf agitation, depression, and hallucinations have been reported dominantly in severely ill elderly patients.

Cardiovascular: Rare reports of tachycardia, bradycardia, an mature ventricular beats.

Gastrointestinal: Constipation, diarrhea, nausea/vomiting abdominal discomfort/pain.

Hepatic: In normal volunteers, SGPT values were increased least twice the pretreatment levels in 6 of 12 subjects rece 100 mg qid IV for seven days, and in 4 of 24 subjects rece 50 mg qid IV for five days. With oral administration there have occasional reports of reversible hepatitis, hepatocellular or he canalicular or mixed, with or without jaundice.

Musculoskeletal: Rare reports of arthralgias.

Hematologic: Rare reports of reversible leukopenia, granul penia, thrombocytopenia, and pancytopenia.

Endocrine: Controlled studies in animals and man have sho stimulation of any pituitary hormone by ZANTAC and no antia genic activity, and cimetidine-induced gynecomastia and tence in hypersecretory patients have resolved when ZANTA been substituted. However, occasional cases of gynecom impotence, and loss of libido have been reported in male pa receiving ZANTAC, but the incidence did not differ from that general population.

Integumental: Rash, including rare cases suggestive of mil thema multiforme, and, rarely, alopecia.

Other: Rare cases of hypersensitivity reactions (eg, bronchos fever, rash, eosinophilia) and small increases in serum creati

OVERDOSAGE: There is no experience to date with deliberate dosage. The usual measures to remove unabsorbed material the gastrointestinal tract, clinical monitoring, and supportive apy should be employed.

Studies in dogs receiving doses of ZANTAC® in exce 225 mg/kg/day have shown muscular tremors, vomiting, and respiration. Single oral doses of 1,000 mg/kg in mice and rat not lethal. Intravenous LD_{50} values in rat and mouse were 8 77 mg/kg, respectively.

DOSAGE AND ADMINISTRATION: Dosage Adjustment for Patient Impaired Renal Function: On the basis of experience with a of subjects with severely impaired renal function treate ZANTAC®, the recommended dosage in patients with a crea clearance less than 50 ml/min is 150 mg every 24 hours. S the patient's condition require, the frequency of dosing m increased to every 12 hours or even further with caution. He alysis reduces the level of circulating ranitidine. Ideally, the d schedule should be adjusted so that the timing of a schedule coincides with the end of hemodialysis.

HOW SUPPLIED: ZANTAC® 150 Tablets (ranitidine hydroch equivalent to 150 mg of ranitidine) are white tablets emboss "ZANTAC 150" on one side and "Glaxo" on the other. Th available in bottles of 60 tablets (NDC 0173-0344-42) an dose packs of 100 tablets (NDC 0173-0344-47).

ZANTAC® 300 Tablets (ranitidine hydrochloride equival 300 mg of ranitidine) are yellow, capsule-shaped tablets emb with "ZANTAC 300" on one side and "Glaxo" on the other. Th available in bottles of 30 (NDC 0173-0393-40) and unit packs of 100 tablets (NDC 0173-0393-47).

Store between 15° and 30°C (59° and 86°F) in a dry place. Protec light. Replace cap securely after each opening.

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basis, waiting for damages to become certain, and assessment of the strength of the opposition. A backlog in the courts may hinder speedy resolution; difficulty in convening panels may delay arbitration. However, legislative or administrative changes may remedy the latter; the former has been and will continue to be a difficult problem for many years.

Appeal of claims under arbitration agreement

Under the MMMAA, appeals are governed by general arbitration law. The courts have acknowledged a "strong public policy in this state favoring arbitration . . . (so that) arbitration clauses shall be liberally construed with all doubts about the arbitrability of an issue to be resolved in favor of arbitration." Between 1978 and 1984, the Michigan Court of Appeals heard just under 50 cases in which claimants challenged the validity or constitutionality of an arbitration agreement. From the records available at the AAA, it appears that fewer than five of the claims the courts found arbitrable were eventually decided by an arbitration panel, and these were denied.

The courts have also considered the scope of the MMMAA. In a recent decision, the court of appeals held that the act encompassed cases of ordinary negligence as well as malpractice because "The legislature intended this statute to be a measure to contain rapidly escalating health costs by reducing litigation." One 1982 arbitration panel, taking contributory negligence into account, awarded damages to a patient who had been admitted to an inpatient alcoholic treatment program. The patient's fall playing ball was attributed to the hospital's negligence in permitting him to play without proper shoes. Although it was not described as ordinary negligence, it would appear to be so, at least as to the extent of the fall from a hospital bed in *Nemzin*.

Further empirical evidence—comparison of outcomes

As difficult as it is to compare outcomes in the court system with arbitration considering the vast differences in the data bases, several studies of litigation in the courts suggest outcomes similar to the Michigan Arbitration Program. In the Michigan Program, of 428 claims closed as of April 30, 1985, dispositions included:

- 169 claims settled: 40.1 percent
- 102 claims determined by arbitration panel: 24 percent
- 80 claims withdrawn: 19 percent
- 62 claims administratively closed: 15 percent (with potential for reopening.)

Thus the Michigan arbitration cases reveal a 47.7 percent overall will rate for plaintiffs, virtually the same outcome as found in a Rand Institute study of malpractice litigation. This same Rand study of court cases, based on 1974 and 1976 claims, revealed a mean award of $102,000 and a mean settlement of $26,000. The top five percent of awards accounted for 49 percent of all the pay out. Without that top five percent, the pattern of awards is similar to that of the Michigan Arbitration Program.

If arbitration promises fewer high awards, there is the probability that some plaintiffs will prefer the courts. However, if arbitration promises a more rational level of compensation with an expectation that it will be appropriate across the board, then there certainly is an incentive for those not suffering from extreme injury or with a questionable cause of harm to arbitrate their claims. Tort reform proposals for capping damages, particularly for pain and suffering, would provide some impetus for arbitration as a forum in view of the fact that the likelihood of a lower court award has been shown to discourage litigation.

Revising the program and creating incentives for utilization

The Michigan Malpractice Arbitration Program has worked well for a decade. It allows resolution of disputes more rapidly than in the courts, and is less costly. Comparisons with the formal adjudication system suggest that outcomes are similar. Nevertheless, arbitration has been underutilized. Many reasons are given for its lack of general acceptance, but none pose insurmountable problems.

We have found some deficiencies which, if corrected, should make arbitration better and more attractive for the resolution of malpractice disputes. The primary deficiencies are the lack of assurance that the decision-making process conforms to statutory requirements; and the arbitration panels' apparent lack of attention to the statutorily mandated detail to be included in opinions. Both of these deficiencies may affect panel decisions. The other matter of concern has been the time required from the incident to award of settlement.

Revising the program

Understanding the need for privacy in arbitration and the belief of some that ad hoc arbitration is superior to precedential arbitration, we suggest that the opinions being generated in the malpractice arbitration program be made available to groups with a legitimate interest in the process for two reasons: to affect future behavior insofar as panel awards may be applicable, and to permit evaluation of medical malpractice arbitra-

Continued on page 420

tion in the context of its statutory design. We would envision either a subcommittee of the arbitration advisory committee or some state agency or its designee being responsible for review of these opinions in the context of the arbitration statutes.

There is a need to ensure the understanding that expert witnesses are not necessary for establishing that standard of care. One step which could be taken immediately is more extensive education of the arbitrators and lawyers. The statutory provisions for designing awards and greater clarity in writing opinions also need to be addressed.

Despite the fact that arbitration has been less time-consuming than the courts, individual proceedings have been plagued with numerous postponements and other delays. The AAA has suggested increasing the penalties for multiple delays so that they are more in line with those levied in commercial and labor arbitration; and requiring that parties respond to lists of prospective panelists in seven rather than 20 days. The latter, however, might well prove to be a logistical problem, and unsatisfactory to both claimants and defendants.

Creating incentives for utilization

Voluntary binding arbitration as an alternative to the court/jury system not only decreases the costs of adjudication, but also reduces disaffection costs inherent in formal adjudication. Now that arbitration has been shown to be a satisfactory alternative to the courts, the question remains of how to increase its utilization.

The unfamiliarity of both the public and the legal profession with the process of arbitration has been apparent since the beginning. This lack of familiarity has allowed unreasonable biases against the system to go unchallenged, and has prevented utilitzation that might well have resulted from a better understanding. To this end, it is essential that an intensive public and professional educational program be under taken. This effort would be the responsibility of the insurance commissioner, and could easily be done with the assistance of the arbitration advisory committee and its subcommittee on education.

We believe that the legislature should require self-insured as well as commercially-insured hospitals to participate in the Michigan Arbitration Program. To accomplish this would necessitate a new sanction for noncompliance, as the only one which now exists is the requirement that commercially-insured hospitals offer arbitration as a condition of their insurers being permitted to do business in this state. If the legislature were to extend the scope of the Michigan Arbitration Program to self-insured hospitals, then the sanction for noncompliance could be tied to hospital licensure.

Proposals to permit the offering arbitration as part of individual and group health insurance contracts are currently before the legislature.

Conclusion

The Michigan Medical Arbitration Statutes permit voluntary binding arbitration of medical malpractice disputes. In spite of many legal challenges and continuing opposition from the plaintiff bar, the process has demonstrated that it is a viable alternative to the court/jury system. The problems which have been identified are soluble. What is most needed at this time is an appreciation of the fact that alternate systems of dispute resolution may better meet needs that the court system cannot fulfill.☐

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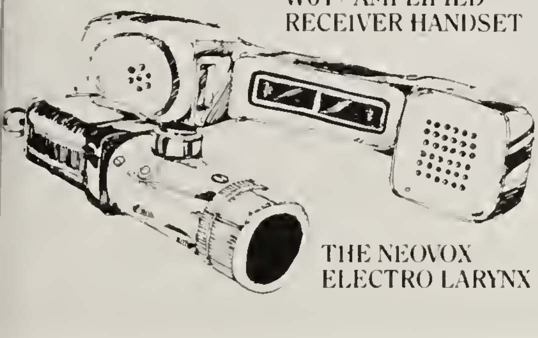

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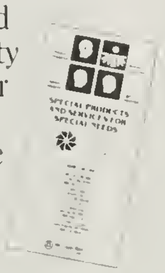

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Leaders hold liability forum

MSMS President-elect Carl A. Gagliardi, MD, told leaders of county medical and specialty societies June 11, "We don't intend to stop now!"

DeGROW
DODAK
MICHIGAN STATE MEDICAL SOCIETY
PAXTON
GAGLIAR

Louis Zako, MD, chairman of the MSMS Task Force on Professional Liability told the group, "Things are not wonderful," referring to the liability package. "There is still a lot to be done," he said. Lawmakers DeGrow and Dodak, Doctor Gagliardi and legal counsel Dick Weber are pictured at the head table.

Co-chairman of the House/Senate conference committee Rep. Lewis Dodak (D-Montrose) said it was tough to sell the compromises to the House. He fully anticipates further liability legislation "down the road."

DODAK
MICHIGAN STATE MEDICAL SOCIETY

Sen. Daniel DeGrow (R-Port Huron), co-chairman of the House/Senate conference committee, said of the package, "It obviously is not what the Senate wanted." But, he called the legislation "a step forward."

hotos by
attrick Yockey

eter Duhamel, MD, chairman of
e MSMS Hospital Medical Staff
ction, challenged the legislators
the seven exceptions to the
25,000 cap on pain and suffer-
g. He maintained they render
e cap useless.

SMS Chairman of the Board of
irectors Robert E. Paxton, MD,
old the audience, "We got what
e did because of a united, con-
erned membership — we don't
ant to lose that. Stay with us in
his new approach."

By Robert M. Leitch, MD

How will tort reform affect professional liability premiums?

Now that tort reform (Michigan-1986 version) is a *fait accompli*, the foremost question in the minds of most physicians is its effect on professional liability insurance rates. We must realize that the new laws which have been passed by the Legislature and signed by the governor do not accomplish the goals which we sought a year or more ago. Nor do they have the potential for improvement of the professional liability situation which the original Senate bills passed in 1985 would have had.

As we look at the new law, we find some possible positives and negatives as a result of their passage. We must realize that it will take a significant amount of time for their ultimate effects to be determined. Some will be challenged for constitutionality and may be discarded. Some may conflict with other legislation that would take precedence. The interpretations by the court and and the Insurance Bureau may be at variance with our present perceptions of their effectiveness.

Leitch

It appears that some of the measures will have a definite positive effect. Changes in collateral source rules should have a significant effect if the courts actually reduce judgments by the amount of collateral source payments. There may be some stumbling blocks in implementation of this rule, but we look for some positive impact.

The changes in the prejudgment interest payments should also improve our situation. At present, the lower interest rate is favorable. The

Continued on next page

Doctor Leitch is president of Michigan Physicians Mutual Liability Company (MPMLC) and secretary of the MSMS Board of Directors.

elimination of interest on "future damages" is a definite improvement.

Greatest potential

Possibly the change with the greatest potential for improvement may be the new statute of limitations. The statute of repose setting a maximum of six years from date of incident for filing is an improvement. The lowering of limits for minors to age 15 also should help. The "tail" should be shortened, thus eliminating two percent to four percent of the claims which are filed under the present statute.

The portion of the law regarding structured payments may have a slight positive effect in some cases. The law, which applies to verdicts over $250,000, will probably not make a significant difference because of the high limit which means only a small percentage of Michigan Physicians Mutual Liability Company (MPMLC) cases will be affected.

The affidavit of non-involvement should remove some doctors named in suits from those suits at an early date, saving defense costs for the insurance company and anxiety for the involved physicians. If challenged by the plaintiff, the physician may be held in the claim, even if his involvement is non-existent or minimal.

The so-called non-economic cap may have a moderate effect. Many of our claims, probably in excess of one-half, would meet one of the exceptions in this law, so it remains to be seen whether or not it will have a significant effect.

The new measure regarding frivolous suits may have a minor impact, but since the courts find virtually no frivolous suits, probably the effect will be minimal.

Negative effects

Some of the new measures will have a definite negative effect on our business and thus on our premium structure. The affidavit of merit provision gives the defense 90 days to file a response to a claim or to post a $2,000 bond. Since it usually takes longer than 90 days to obtain records, take dispositions, get expert reviews, etc., it appears that we will be posting bond in most cases, thus increasing costs.

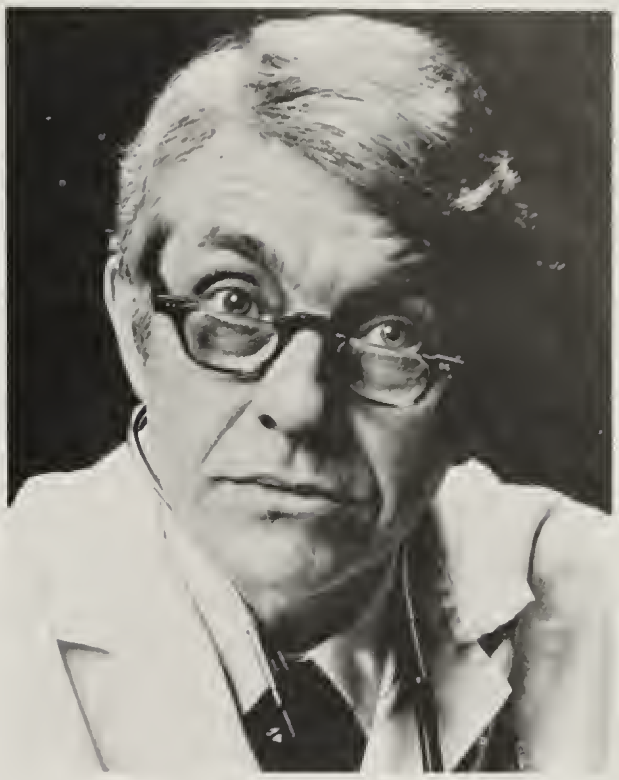
The new mediation effort will probably prove more costly. If the mediation panel finds either the complaint or defense to be "frivolous," that party must post a $5,000 bond to proceed. Our history with mediation to date indicates that we have successfully defended numerous cases where mediation awards have been made. This system will also require extra time and costs on the part of the defense.

Due to the timing of the new laws, there will be no immediate effect which might lower rates. The cap, the statute of limitations, and joint and several changes apply to incidents occurring after October 1, 1986, so it will take these incidents several years to appear in court. Changes in mediation and pre-judgment interest on future damages apply to cases *filed* after January 1, 1987, so here again there will be no immediate effect.

One of the new measures incorporated in HB 5209 (insurance package) will have another negative effect. This law markedly changes our surcharge policies and has the potential to lower our surcharge premium by as much as two-thirds. This will almost certainly exert an upward pressure on basic rates. In addition, there is a possibility of a definite effect on insurance availability since there will be a tendency to cancel or nonrenew a physician who is surcharged under the present system.

It will take several years for the effects of the new laws and any subsequent improvements in them to be realized. In the meantime, any reduction of premiums based on possible improvement would be "betting on the come" and would not be likely to be approved by actuaries or the insurance bureau even if a company were to attempt reduction. The pressures for lower rates from physicians, organized medicine, consumers' groups, trial lawyers and others must be resisted vigorously. Those who state that the insurance companies are making inordinate profits while continuing to raise rates need only to look at the reinsurance market which has dried up both in domestic and foreign markets. Our consulting actuary, Mr. Lee Smith of Ernst & Whinney, recently pointed out an example of apparent profitability turning to loss. Employers of Wausau wrote medical malpractice insurance from 1968 through 1974. When they stopped writing they had collected $167 million in premiums and had paid $70 million in losses. So it would appear to the uninitiated that here was a $97 million profit. By 1983 however, the company's ultimate liabilities amounted to $340 million in losses. Thus, instead of making a profit of $97 million, they had sustained an underwriting loss of $200 million, far in excess of investment income generated.

It is our fondest hope at MPMLC that premiums will be reduced as a result of present and future legislative effort supplemented by effective loss prevention activities to reduce our exposure to losses. Since we have no profit motive, any savings in this area will be passed along to policyholders as soon as they are realized. A financially sound MPMLC is in the best interest of the doctors of Michigan. Rate reductions based on the perceived future effects of these new laws could jeopardize that soundness.☐



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Please see brief summary of prescribing information on the next page.

CARDIZEM® 60 mg tid or qid

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FEWER SIDE EFFECTS IN ANTIANGINAL THERAPY

BRIEF SUMMARY

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist).

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic)

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM (diltiazem hydrochloride) in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation

Pediatric Use. Safety and effectiveness in children have not been established

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are. edema (2.4%), headache (2 1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1 1%) In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System.	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia
Gastrointestinal	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity
Other.	Polyuria, nocturia

The following additional experiences have been noted.

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM erythema multiforme, leukopenia, and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered

Bradycardia	Administer atropine (0 60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy** — CARDIZEM may be safely co-administered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

CARDIZEM 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other. Issued 4/1/84

See complete Professional Use Information before prescribing.

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References: 1. *Physicians' Desk Reference®,* ed 39. Oradell, NJ, Medical Economics Company Inc, 1985. **2.** Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed). *Heart Disease. A Textbook of Cardiovascular Medicine*, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39. **3.** Schroeder JS· Calcium and beta blockers in ischemic heart disease. When to use which. *Mod Med* 1982; 50(Sept) 94-116. **4.** Subramanian VB. Comparative evaluation of four calcium antagonists and propranolol with placebo in patients with chronic stable angina *Cardiovasc Rev Rep* 1984; 5:91-104. **5.** Schroeder JS, Feldman RL, Giles TD, et al. Multiclinic controlled trial of diltiazem for Prinzmetal's angina. *Am J Med* 1982; 72:227-231. **6.** Weiner DA, McCabe CH, Cutler SS, et al. The efficacy and safety of high-dose verapamil and diltiazem in the long-term treatment of stable exertional angina *Clin Cardiol* 1985; 7:648-653. **7.** Shapiro W Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. *Consultant* 1984, 24(Dec):150-159.

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By Herbert A. Auer

What's happening with hospitals?

What are MD and hospital leaders saying? hat's with holding compaies, joint ventures? And how bout hospital advertising and ecruiting?

The contention behind this verview type of article is that iost dedicated physicians conentrate their efforts on servig their patients . . . but they iay understand little about the ioves of their own hospital nd trends today.

Let's begin with some specif happenings and close with ome quotations from MD and ospital leaders.

All across Michigan, medical are services are being proided in small (and large) comiunities by offices and staffs nanced by hospitals. Which ospital has the most "sateltes" serving the underserved r competing to assure referals? We don't know. A numer of them have three or four uch outposts. One town that ad no physicians now has two atellites — operated by a ospital to the east and a ospital to the west.

MD and DO hospitals are anding together to offer ome of these services coopertively.

Some hospitals are "leaprogging" over another hospial to more vigorously comete for a possible flow of atients from a new service rea.

Where will all this stop? Who knows?

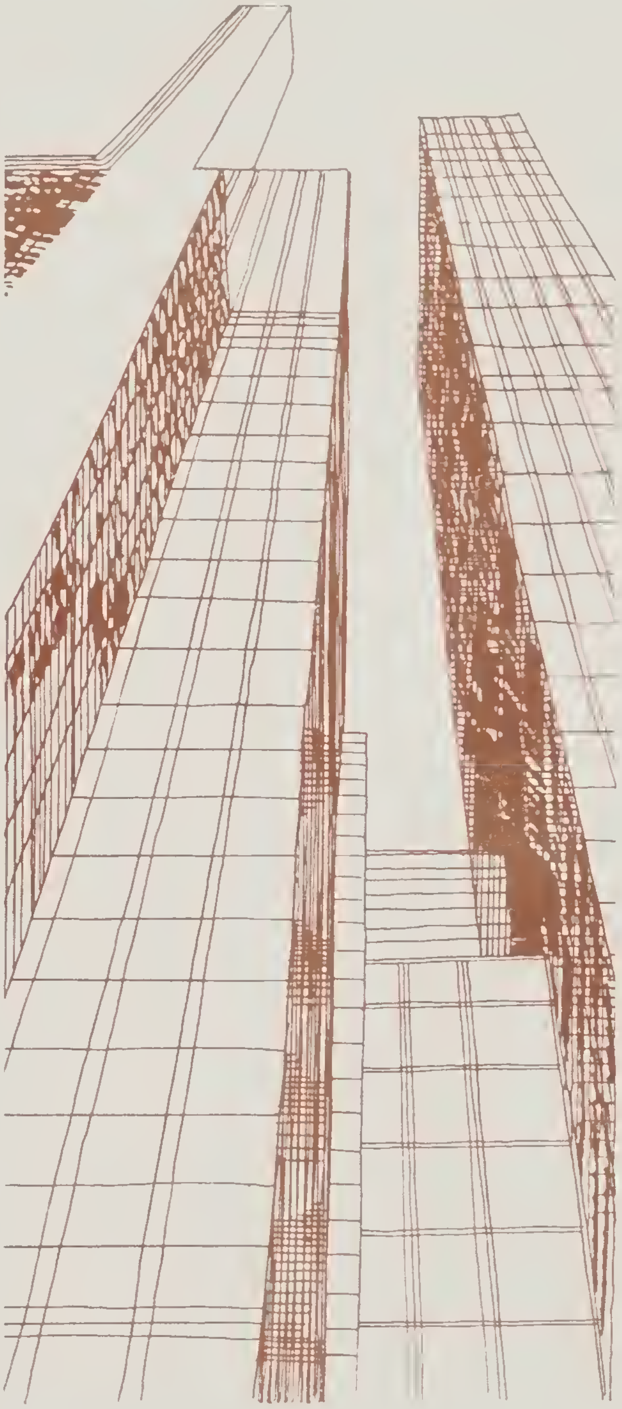
"Hospitals more than ever before are providing community leadership in the recruitment of new physicians to Michigan towns," observes Paul E. McNamara, chairman of the Michigan Health Council (MHC) and president of Clinton Memorial Hospital in St. Johns. A total of 75 communities in Michigan are registered with the MHC Physician Placement Service as having one or more opportunities for physicians. Mr. McNamara reports, "Many hospitals are providing upfront financial assistance, minimum guarantees, and assistance with professional liability insurance to help new physicians get established. Physician coverage through hospital liability contracts is helping to convince some doctors to stay in or to come to Michigan to practice."

Other uses

A small number of Michigan hospitals during the past several years have discontinued operation as hospitals. Several of those facilities are still used for a variety of health care services to their communities.

Among the hospitals that have phased out are those at Onekema, Grant and Douglas.

Some other Michigan hospitals, for various reasons including declining patient counts, have developed new affiliate relationships in a variety of



Continued on page 430

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r. Auer is former MSMS deputy irector, and former editor of *ichigan Medicine.*

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patterns with nearby larger hospitals, and some have entered into management contracts with larger hospitals or with for-profit firms located outside Michigan.

One tactic in all phases of business is to advertise more and market more vigorously when income falls. Michigan hospitals indeed are using more newspaper advertising and radio and TV time than ever before to reach the public.

"I have never seen so many ads in our newspapers for hospitals," declares Warren Hoyt, executive of the Michigan Press Association. Hospitals are buying space to tell about new services and to encourage health maintenance. So are the HMOs in Michigan.

"MPA has had requests from newspapers to help with the development of special sections as a new advertising technique that interests hospitals," Mr. Hoyt says.

And, billboards are cropping up where motorists enter Michigan towns as they travel, and in bigger cities as hospitals market their name.

Hospitals have found that spin-off services are a safe and easily-understood venture into health-related businesses. One of the most common in Michigan, and the nation, is the development and operation of home health services.

New ventures

Two other common new ventures for Michigan hospitals have been with hospices and health promotion programs.

A friend recently commented that every time he listens to the radio these days some hospital is promoting a fitness run, a nutrition workshop or a stop-smoking clinics. And the competition is lively in communities with more than one hospital.

MHA statistics for 1984 reveal that 139 of 195 reporting hospitals are engaged in health promotion (HP) programing. A major grant from the W.K. Ke logg Foundation of Battle Creek to the MHA service corporation has financed selecte hospitals with innovative HP programs and has permitted MHA to offer seminars. The AMA staff also has resources available.

The hospital is a logical moving force in the communi to provide good health information and to challenge Mich gan residents to live healthier lifestyles. The hospital has th facility, the parking lot, the professional staff, a board of business and civic leaders, a workable network of involved community groups and a proven record in public relations.

Progress comes slow. Abou 20 years ago, the MSMS Hous of Delegates adopted a resolution requesting hospital board of directors to include one or more physicians as voting members. There was little acceptance of that request at that time. Now, MSMS has learned from a survey returne from 109 chiefs-of-staff that 90 percent have physician representatives on the hospita board with an average of two on a 16-member board.

MSMS staffers handling inquiries regarding hospital-medical matters report some increase in questions about hospital privileges. The same survey, mentioned above, found that five percent of the respondents reported having a closed medical staff.

Many physicians participate May 28 in a seminar sponsore by the MSMS Hospital Medical Staff Section to consider ways that physicians can benefit from joint venturing with hospitals. Other co-sponsors were the Wayne County Medical Society Hospital Medical Staff Section and the Southeas Michigan Hospital Council. Details about future possible seminars on joint venturing

Continued on page 432

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Phone (517) 337-1351

may be obtained from Tom White at MSMS headquarters.

While many changes are taking place across Michigan every day, as cited above, MD leaders, hospital authorities and executives are concerned about both the present pressures and those seen ahead. All agree that the health care industry is much different now than just five years ago — and dramatic changes will take place before 1990 or 1995 and surely by 2000.

Concerns and predictions

These following comments express some of today's concerns and predictions and tip us off to the future.

"Most of all what I want," Peter A. Duhamel, MD, of Rochester, recently told a western Michigan hospital board of trustees, "would be to recover the traditional relationship of mutual trust between the medical staff and the hospital."

Doctor Duhamel, chairman of the MSMS Hospital Medical Staff Section, went on, "We can achieve the best results for both hospital and the medical staff by working together as teammates for our mutual benefit, in fact for our very preservation and survival."

He cautioned hospitals from "entering into private, secret, exclusive, advantageous arrangements for the hospital with a few eager (or gullible) practitioners, leaving the rest of the staff on the outside."

Doctor Duhamel told the hospital trustees that "the most sinister aspect of this new economic, competitive, and litigious crisis is that we (physicians) are starting to realize that our former benefactor — our rock, our fortess, the hospital — is not necessarily our friend any more." He expressed sadness over this development and pleaded, "Please keep open the lines of communication that can lead to mutual respect, trust and understanding. It is critical that special care and attention be given to nurturing a relationship that will benefit both groups." (from *Michigan Hospitals*, April 1986)

MHA president summarizes

"Key to changes for hospitals is the more competitive environment that has opened the door to aggressive hospital marketing and advertising strategies. The growth in mergers and affiliations among hospitals is also dramatic. Joint ventures are springing up across the state. Michigan hospitals are engaging in cooperative arrangements with each other to share services and purchase expensive medical equipment, or with physicians to build medical office buildings and to open clinics in outlying areas. PPOs, IPAs and other innovative arrangements with businesses all are becoming incorporated into Michigan hospitals' long term strategies," said Spencer C. Johnson, president and chief executive officer of the Michigan Hospital Association, in a recent issue of MHA's *Michigan Hospitals* journal.

True, we read and hear a great deal about the predictions that there will be eight national corporations delivering or purchasing health throughout in the country.

That crystal-ball forecast is blasted hard by the MHA executive. Johnson declared before the 1986 MHA smaller hospitals conference, "Health care is a local product, a human service that we want to get on our block, in our community, in our region, preferably. Those health care corporations out there are not going to engulf Michigan."

When the Mayo Clinic opened a branch clinic in Jacksonville, Florida a state law was changed to permit Mayo physicians to take only an oral test in their specialties instead of the lengthy comprehensive exam that all other physicians must pass to get a state license. Understandably, the president of the Florida Medical Association protested. Luis M. Perez, MD, said, "We welcome competition, but not unfair competition like that."

This article is not complete without mentioning that the Mayo Clinic also opened a branch in Scottsdale, Arizona, and merged in Rochester, Minnesota, with two local hospitals to become the complex of the world's largest private medical center with 830 physicians admitting 1,000 patients a day. *Business Week* recently reported that the Cleveland Clinic is considering a group practice in Fort Lauderdale.

A national consultant lists changes

". . . hospitals face challenges to their survival in an environment that is becoming increasingly quick-changing, perilous, stressful, unforgiving, opportunistic, competitive, innovative, challenging and entrepreneurial," observes Leland R. Kaiser, PhD, president of a health care consulting firm in Colorado. H conducted a day-long management seminar in Lansing this summer, sponsored by Ingham Medical Center, St. Lawrence and Lansing General hospitals.

Doctor Kaiser, a recognized futurist in the hospital field, has identified these important trends: 1) changing reimbursement; 2) emergence of competition; 3) declining resources; 4) emergence of chains; 5) movement of primary care outside the hospital; 6) new payment mechanisms; 7) increased need for marketing; 8) hospital physician joint ventures; 9) corporate reconfiguration.

"Old forms and traditions in health care are dying, and new forms are emerging that are better adapted to the challenges of a changing age," Kaiser says.☐

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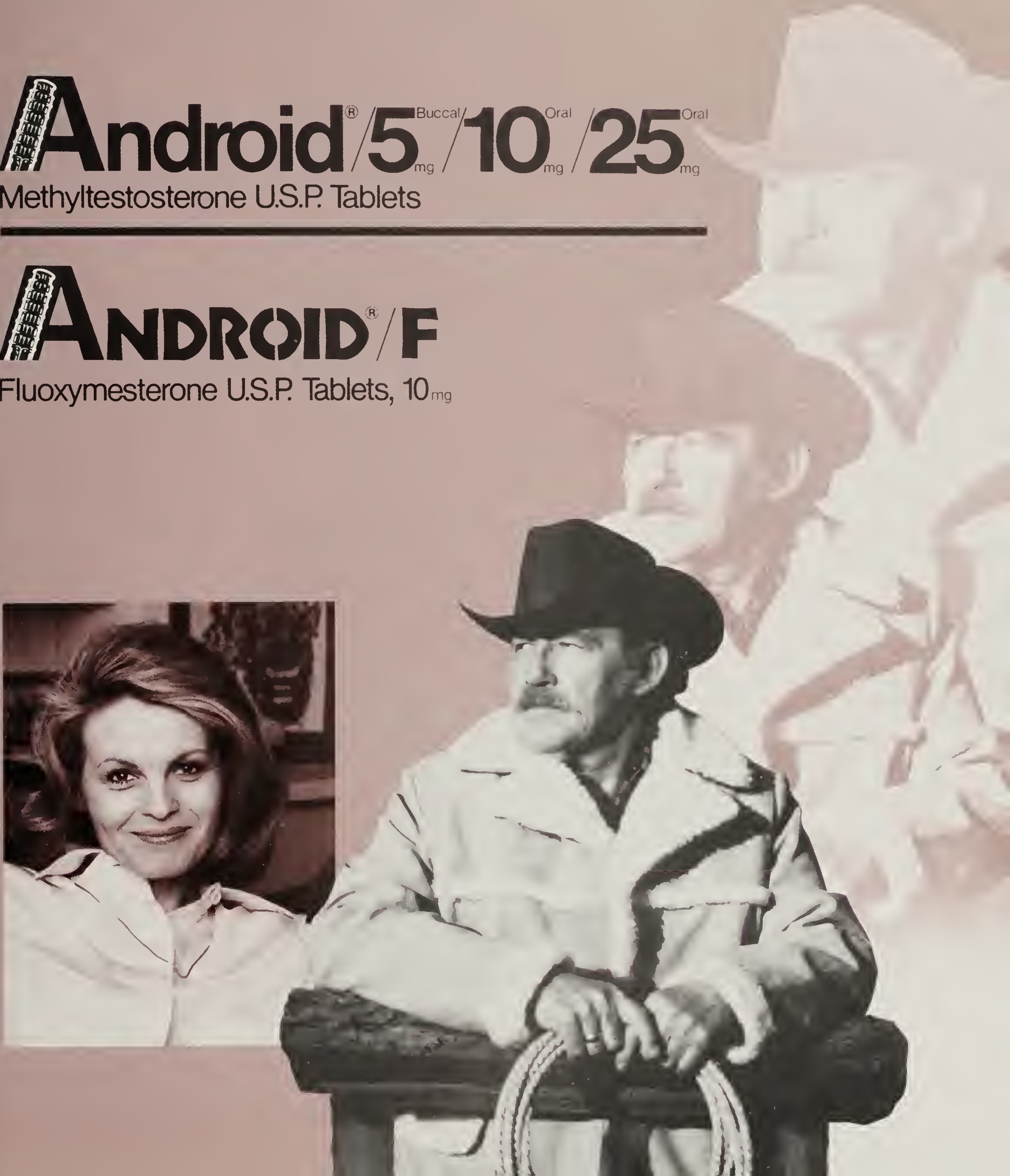

John J. Coury, MD, AMA President

One of our own leads the nation's physicians

John J. Coury, MD, Port Huron general surgeon, became president of the American Medical Association June 18 during the AMA's annual meeting in Chicago. His goal, as it has been throughout his medical career, is to "maintain quality care for the patient — and that means being a patient advocate."

Code for living

This code is excerpted from a speech Doctor Coury gave on May 9, 1985, at an Academic Awards Dinner for outstanding Port Huron students. He stated that these are the rule by which he has lived throughout his career.

- Identify your goal and dedicate your efforts in an organized fashion to achieve i through work, study, community involvement or all three.
- Develop a code of conscience, morals and ethics. If you can't live with your conscience, you may be successful, but you won't be happy. I you do not have ethics, you may be successful, but you won't be respected.
- Never hate people. The more you love, the more you will be loved.
- Give your full effort to whatever job you do. If you don't like it, quit; but never give less than your best.
- All great leaders have ha faith.
- Never abandon your family. Your family helped make you what you are.
- Leave a legacy you can b proud of. Give more than you receive. Use your right to vote and take an active part in you community, because its future rests on you.☐

s obvious that Mrs. Dorie Coury
pleased and proud that her
ouse will lead the nation's phy-
cians for the next year.

Doctor Coury is sworn into office by William W. Hotchkiss, MD, past chairman of the AMA Board of Trustees and now AMA president-elect. MSMS is proud that Doctor Coury is the fifth Michigan physician to serve as AMA president. The others were Zina Pitcher, MD (1856-57); William Brodie, MD (1886-87); Donald MacLean, MD (1895-96), and Victor Vaughan, MD (1914-15).

AMA
AMERICAN MEDICAL ASSOCIATION
JOHN J COURY, JR
PRESIDENT 1986-87

ank B. Walker, MD, right, vice-chairman of the MSMS Board of Directors, presented Doctor Coury with a
ample of his handiwork — a framed, AMA seal done in needlepoint. Robert W. Black, MD, looks on from left.

Fibrocystic disease does not foretell breast cancer—brochure available

A recent consensus statement, approved by the College of American Pathologists' Board of Governors, said that women who develop fibrocystic disease of the breast are not necessarily more likely to develop breast cancer in the future. A reprint of this statement appeared in the March, 1986 issue of *Archives of Pathology and Laboratory Medicine*.

The College of American Pathologists has developed a patient brochure, "Is Fibrocystic Disease of the Breast Precancerous?" To request a supply write to:

William L. Kuehn, PhD,
Director of Public Services,
College of American
Pathologists, PO Box 566,
Skokie, IL 60076

Diseased bone treatment shows promise

A seldom-used method of restoring full, healthy use of a patient's arm or leg after bone cancer surgery—without transplants of artificial implants—has shown encouraging results for wider application.

A pilot study recently completed at the University of Michigan shows promise for the technique of removing the cancerous bone, killing the disease cells under high temperature and pressure, replacing the bone and then nurturing it as a fracture.

Although the bone tissue is killed along with the cancer, the study indicates that living tissue grows into the sterilized segment and, in effect, brings it back to life.

"This has increased our enthusiasm for the procedure, b we need to make the laboratory model more like t human situation," said Steve Goldstein, PhD, assistant professor of surgery and interim chairman of the bioengineeri program at the U-M Medical Center, who has been conduc ing animal trials on the procedure.

"We need to know more about it before doing it routinely," he said. "We don know how best to follow up the surgery."

Fractures can be nurtured i a number of ways, including placing the limb in a cast or i serting a metal rod through t core of the fractured segmen so it extends into the healthy bone and holds the segment i place. It is not yet known which method works best wit the bone cancer treatment.

William S. Smith, MD, professor of surgery at the U-M Medical Center, has over the past 20 years used the treatment on 10 or 12 patients with low-grade chondrosarcoma to salvage their affecte limbs. Goldstein's pilot study examined more closely the ou come of the procedure to evaluate for wider use.

Alternatives to the treatme include amputation or replacing the affected bone with a transplant from somewhere else on the patient's body, or with a donor transplant or artificial implant of metal or plastic.

"The most important factor is that the removed bone segment is a perfect fit for reimplanting, and you don't need a donor," Goldstein said "We're not saying this in goin to replace other treatments, but it is another option that may be effective."

In the pilot study, a segmen of the femur, the bone between the hip and knee, was removed from 16 sheep and sterilized under high tempera-

Continued on page 43

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Positions are available throughout Michigan in an emerging program designed to provide comprehensive, coordinated and continuing care to mentally disordered prisoners within the Michigan Department of Corrections. Openings exist in a variety of settings, including acute inpatient units, long-term care units, transitional care units, and outpatient programs.

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An Equal Opportunity/Affirmative Action Employer prescribing, see complete prescribing information in SK&F CO. re or *PDR*. The following is a brief summary.

RNING

drug is not indicated for initial therapy of edema or hypertens. Edema or hypertension requires therapy titrated to the individual. is combination represents the dosage so determined, its use be more convenient in patient management. Treatment of hyperion and edema is not static, but must be reevaluated as conns in each patient warrant.

indications: Concomitant use with other potassium-sparing agents is spironolactone or amiloride. Further use in anuria, progressive r hepatic dysfunction, hyperkalemia. Pre-existing elevated serum ium. Hypersensitivity to either component or other sulfonamide- drugs.

ngs: **Do not use potassium supplements, dietary or otherwise, hypokalemia develops or dietary intake of potassium is markedly ed.** If supplementary potassium is needed, potassium tablets not be used. Hyperkalemia can occur, and has been associated ardiac irregularities. It is more likely in the severely ill, with urine e less than one liter/day, the elderly and diabetics with suspected firmed renal insufficiency. Periodically, serum K⁺ levels should be ined. If hyperkalemia develops, substitute a thiazide alone, restrict take. **Associated widened QRS complex or arrhythmia requires t additional therapy.** Thiazides cross the placental barrier and r in cord blood. Use in pregnancy requires weighing anticipated ts against possible hazards, including fetal or neonatal jaundice, bocytopenia, other adverse reactions seen in adults. Thiazides r and triamterene may appear in breast milk. If their use is essential, itient should stop nursing. Adequate information on use in children available. Sensitivity reactions may occur in patients with or with- history of allergy or bronchial asthma. Possible exacerbation or tion of systemic lupus erythematosus has been reported with de diuretics.

utions: The bioavailability of the hydrochlorothiazide component of ide' is about 50% of the bioavailability of the single entity etically, a patient transferred from the single entities of triamterene ydrochlorothiazide may show an increase in blood pressure or fluid ion. Similarly, it is also possible that the lesser hydrochlorothiazide ailability could lead to increased serum potassium levels. However, sive clinical experience with 'Dyazide' suggests that these conditions not been commonly observed in clinical practice. Angiotensin- rting enzyme (ACE) inhibitors can elevate serum potassium; use caution with 'Dyazide'. Do periodic serum electrolyte determinations cularly important in patients vomiting excessively or receiving teral fluids, and during concurrent use with amphotericin B or costeroids or corticotropin [ACTH]). Periodic BUN and serum inine determinations should be made, especially in the elderly, tics or those with suspected or confirmed renal insufficiency. lative effects of the drug may develop in patients with impaired renal ion. Thiazides should be used with caution in patients with impaired tic function. They can precipitate coma in patients with severe liver se. Observe regularly for possible blood dyscrasias, liver damage, idiosyncratic reactions. Blood dyscrasias have been reported in nts receiving triamterene, and leukopenia, thrombocytopenia, ulocytosis, and aplastic and hemolytic anemia have been reported thiazides. Thiazides may cause manifestation of latent diabetes tus. The effects of oral anticoagulants may be decreased when concurrently with hydrochlorothiazide; dosage adjustments may be ssary. Clinically insignificant reductions in arterial responsiveness repinephrine have been reported. Thiazides have also been shown to ase the paralyzing effect of nondepolarizing muscle relaxants such bocurarine. Triamterene is a weak folic acid antagonist. Do periodic studies in cirrhotics with splenomegaly. Antihypertensive effects be enhanced in post-sympathectomy patients. Use cautiously in ical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' ld be used with caution in patients with histories of stone formation. w occurrences of acute renal failure have been reported in patients Dyazide' when treated with indomethacin. Therefore, caution is sed in administering nonsteroidal anti-inflammatory agents with zide'. The following may occur: transient elevated BUN or creatinine th, hyperglycemia and glycosuria (diabetic insulin requirements may ltered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), easing alkali reserve with possible metabolic acidosis. 'Dyazide' feres with fluorescent measurement of quinidine. Hypokalemia is mmon with 'Dyazide', but should it develop, corrective measures ld be taken such as potassium supplementation or increased dietary e of potassium-rich foods. Corrective measures should be instituted iously and serum potassium levels determined. Discontinue correc- measures and 'Dyazide' should laboratory values reveal elevated m potassium. Chloride deficit may occur as well as dilutional natremia. Concurrent use with chlorpropamide may increase the risk evere hyponatremia. Serum PBI levels may decrease without signs hyroid disturbance. Calcium excretion is decreased by thiazides. zide' should be withdrawn before conducting tests for parathyroid tion. Thiazides may add to or potentiate the action of other anti- rtensive drugs. Diuretics reduce renal clearance of lithium and ease the risk of lithium toxicity.

erse Reactions: Muscle cramps, weakness, dizziness, headache, mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other matological conditions; nausea and vomiting, diarrhea, constipation, er gastrointestinal disturbances; postural hypotension (may be ravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, esthesias, icterus, pancreatitis, xanthopsia and respiratory distress luding pneumonitis and pulmonary edema, transient blurred vision, adenitis, and vertigo have occurred with thiazides alone. Triamterene been found in renal stones in association with other usual calculus nponents. Rare incidents of acute interstitial nephritis have been orted. Impotence has been reported in a few patients on 'Dyazide', ough a causal relationship has not been established.

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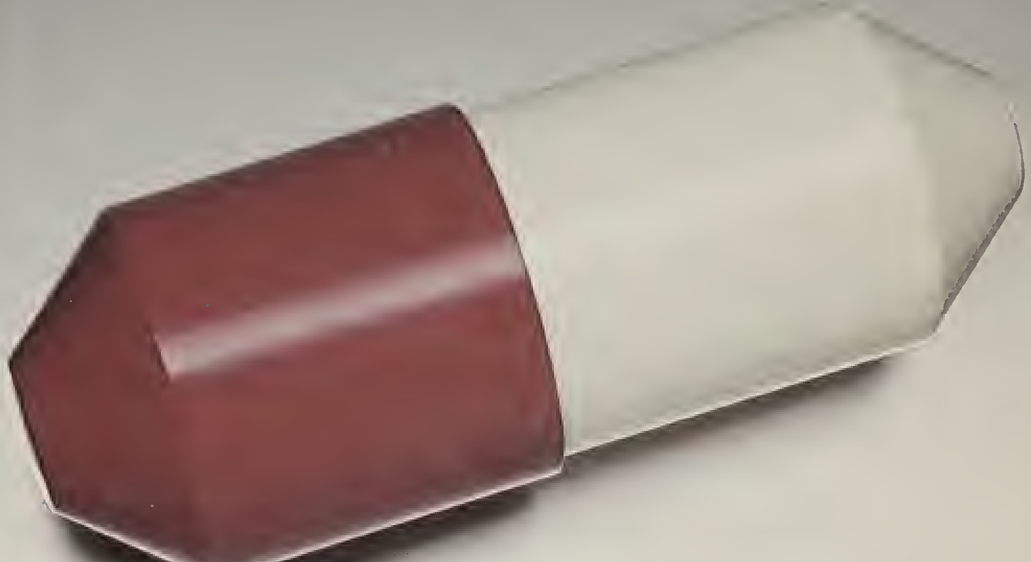

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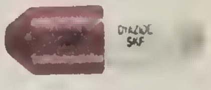

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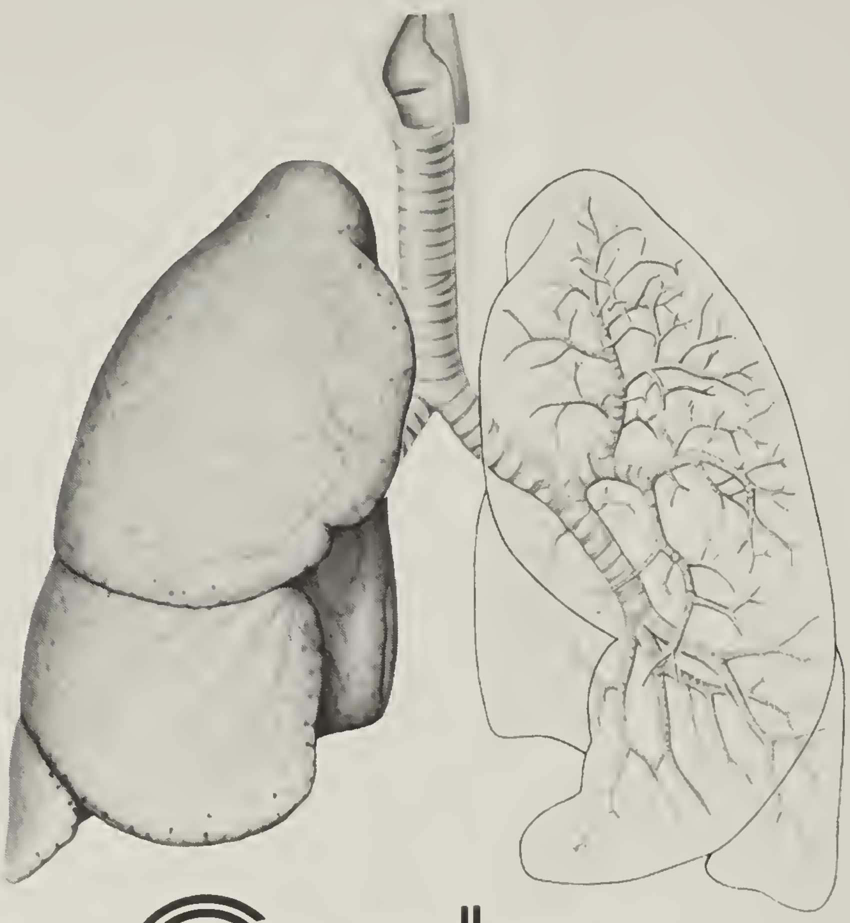

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Note: Ceclor® is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

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Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

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Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%; usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reporte half of which have occurred in patien with a history of penicillin allergy.
- Other: eosinophilia, 2%; genital prurit or vaginitis, less than 1%.

Abnormalities in laboratory results uncertain etiology
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- Abnormal urinalysis; elevations in BU or serum creatinine
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te and pressure as if it were ncerous, then replaced. The lnes were examined at different stages of recovery.

At 12 weeks, the reassemled femur has healed along te fracture lines and was most as strong as the other de. At 24 to 36 weeks, the ne was essentially as strong the other side. After one ar, the bone was as strong echanically as the bone in te other leg, and there was idence that living tissue had grated into and replaced the erilized bone.

"The sterilized bone imants are being re-examined cause of early failure of afts from cadavers. The bond nds to break down for asons not fully understood. eliminary results show the erilized bone implant doesn't eak down," Goldstein said.

Several areas still need to be plored. Experiments are eded in which muscle tissue removed along with the ne, since human surgery ten includes the removal of ighboring muscle to guard ainst the spread of the ncer.

Goldstein also wants to termine if the healing process can be accelerated to duce the amount of time the tient is at risk of complicaons, such as fracturing of the planted bone.

One way Goldstein is condering to hasten recovery ould be to add bone-chip afts to the area where the gment is attached to the althy bone. The grafts would ld surface area to the juncn, increasing the supply of ood and nutrients and prooting healing.

Goldstein said he has found tle reference in medical erature to other research on e bone replacement techque. A report of some animal periments in California and ne or two reports of clinical e have been published, but the technique has been largely ignored.

"Presumably it is suitable for any cancer of the bone in which limb preservation is suitable and there is enough bone material to give it adequate structure following sterilization," Goldstein said. "It just has not had the attention that other procedures have had."

Results of the U-M animal studies have been published as an abstract in Orthopedic Transactions and presented to the Orthopedic Research Society.

Call for abstracts on menstrual research

The program "Sexuality and the Menstrual Cycle: Clinical and Sociocultural Implications," will be held June 4-6, 1987 in Ann Arbor, Michigan. Submission deadline for abstracts is December 1, 1986.

This interdisciplinary program is targeted for researchers, health-care providers, students, and others who share an interest in women's lives and health needs as these relate to the menstrual cycle. We are calling for papers in the areas of: the menstrual cycle—sexual influences; psychology, physiology, anthropology, endocrinology and sociology of the menstrual cycle; interdisciplinary aspects of the menstrual cycle—premenstrual syndrome, dysmenorrhea, menarche, menopause.

Proceedings will be developed from abstracts submitted. If your abstract is chosen, a complete manuscript will be required for printing. Abstracts must be typed and limited to 250 words. Submit an original and one copy; delete author's identity on the copy to facilitate a blind review.

For details contact: S. De Groote, Program Coordinator, Center for Nursing Research, University of Michigan, Ann Arbor, MI 48109-0482 (313) 747-0352.

Vaccine fears and whooping cough

The number of cases of whooping cough has more than doubled in the past three years in the United States, at least in part because some parents are refusing to allow their children to be immunized against this disease due to concern about side effects from the vaccine, reports the American Council on Science and Health (ACSH).

"Parents' concerns about whooping cough vaccine are understandable; there have been quite a few alarming reports of severe reactions suffered by some children after immunization," said an ACSH research associate. "Unfortunately, what most parents don't understand is that major reactions such as seizures and other neurologic problems are extremely rare, and that the types of reactions occasionally associated with vaccination are far more frequent in children who actually get whooping cough."

In 1985, "near-epidemic" outbreaks of whooping cough occurred in Georgia, Hawaii, Indiana, Iowa, Minnesota, Oklahoma, Oregon, and three counties in Texas, according to the American Academy of Pediatrics. Increased rates of the disease and decreased vaccination rates have been noted in other states as well, ACSH reported.

"Because of the controversy over the safety of whooping cough vaccine, the risks and benefits of this vaccine have been reevaluated," said ACSH Executive Director Elizabeth M. Whelan, MD. "The reanalysis showed that the benefits of the vaccine continue to outweigh its risks by a large margin. Without the vaccine, the number of cases of this disease would increase more than 100-fold. ☐

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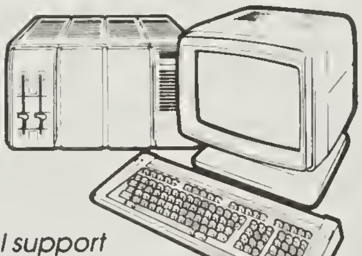

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These AMA reports are available

The following reports were considered at the AMA House of Delegates Annual Meeting in Chicago, June 15-19. Copies are available by contacting Joyce Crum, MSMS Department of Communications, 120 W. Saginaw, East Lansing, MI 48823.

Reports of the AMA Board of Trustees:

Report F—Durable Power of Attorney for Health Care

Report J— Delineating Health Care Expenditures

Report O— Missing and Exploited Children

Report Q— Alcohol: Advertising, Counteradvertising and Depiction in the Public Media

Report R— AMA Policy and Programmatic Activities For an Aging Population

Report T— Final Report of the AMA Task Force on Physician Manpower

Report LL—Health Care of the Homeless Population

Report UU—AIDS Status Report: Quarterly Update

Reports of the AMA Council on Medical Service

Report A— Quality of Care

Report B— Prior Authorization Programs

Reports of the AMA Council on Scientific Affairs

Report A— Results and Implications of the AMA-APA Physician Mortality Project

Report J— Elder Abuse and Neglect ☐

Board of Medicine actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: Jack H. Buck, MD
Action, Date Taken: Reprimand, May 21, 1986
Reason: Negligence in the practice of medicine and betrayed (sic) of a professional confidence.

Name: Edith J. Lee, MD
Action, Date Taken: Suspende thirty (30) days effective on c about 8/11/86; Reprimanded and probation one (1) year.
Reason: Conviction of a crime reasonably related to and adversely affecting her ability t practice medicine and lacking good moral character. (Convic tion of three (3) counts of filing false income tax returns).

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A Conference for Physicians &
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Traverse City, Michigan

1986 Program: 11 CME Hours, Cat. I, (approved); 11 Prescribed hours, AAFP (applied for)
The Munson Medical Center Medical Education Committee is accredited by the MSMS Committee on CME Accreditation and certifies that this activity meets the criteria for a maximum of 11 credit hours in Category I toward the requirements for Michigan relicensure and of the AMA, provided it is completed as designed. (A total of 9 credits will be awarded for attendance at presentations; 2 additional credits are available for the breakfast Topic Table panels).

Contact: Dr. Charles W. Bethea, Director, or Helen Wilcox, Secretary , Alcohol and Drug Treatment Program, Munson Medical Center, phone: 616-922-9383

Co-sponsors: Chemical Dependency Committee, Medical Staff
Alcohol and Drug Treatment Program
Munson Medical Center
Traverse City, MI 49684

DEATHS

Honorato Barrios, MD
Hancock

Doctor Barrios, the first foreign-born physician to establish a practice in Hancock, died April 21, at the age of 64. Doctor Barrios, a native of Peru, received his degree in medicine in 1953 from the Universidad de San Marcos in Lima, Peru. Doctor Barrios served his internship at McKennon Hospital in Sioux Falls, South Dakota in 1954 and moved to Michigan in 1955. He was medical director of the Houghton County Medical Care Facility since 1982. Doctor Barrios returned to Peru a number of times both for pleasure and to visit rural and urban hospitals to teach and perform surgery.

Ellis J. Bolan, MD
Suttons Bay

Doctor Bolan, 84, a Suttons Bay physician for more than 40 years, died April 22. Doctor Bolan received his medical degree in 1933 from Wayne State University College of Medicine. He was a member of the Michigan State Medical Society and the American Medical Association. Doctor Bolan had been on staff at Munson Medical Center until his retirement in 1978.

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James B. Cooper, MD
Grosse Pointe

Doctor Cooper died May 19, at the age of 79. Doctor Cooper was a staff member at St. John's Hospital, and at Providence Hospital in Detroit. He received his medical degree from Wayne State University College of Medicine in 1935. He was remembered by many patients for the house calls he made until his retirement in 1976.

Murray M. Deighton, MD
Southfield

Doctor Deighton, a team physician for North Farmington High School, died April 13, at the age of 56. Doctor Deighton received his medical degree in 1956 from Wayne State University College of Medicine. He maintained a practice in Farmington for 15 years before becoming a staff member at Providence Hospital in 1969. There he was director of the Family Practice residential program and chairman of the Department of Family Practice. Doctor Deighton taught at Wayne State University and at Michigan State University.

Larry E. Heath, MD
Rochester

Doctor Heath died April 9, at the age of 44. Doctor Heath received his medical degree from the University of Michigan Medical School in 1968. He served as a Captain in the US Army for three years in Germany. Upon completion of military service he returned to Mt. Clemens where he established his practice in dermatology. Doctor Heath was recently elected president of the Dermatology Association of Michigan.

Frederick T. Mannion, MD
Cadillac

Doctor Mannion died April 29, in a bicycle accident. He was 33. He received his medical degree from Baylor College of Medicine, Houston, in 1975. He practiced ophthamology in Cadillac and was credited with introducing two types of laser eye surgery to the Cadillac area. Doctor Mannion also performed Mercy Hospital's first cornea transplant. He was past president of the Wexford-Missaukee Medical Society.

Robert C. Moehlig, MD
Harbor Springs

Doctor Moehlig, 96, died April 13. Doctor Moehlig received his medical degree in 1913 from the Detroit College of Medicine (now part of Wayne State University). He was well known for his work in endocrinology and internal medicine. He also was well known for his bedside manner. Doctor Moehlig served as a Captain in the US Army Medical Corps in 1917-18. He was chief of medicine at Harper Hospital for five years and chief of its diagnostic clinic for nine years. He was also a professor at Wayne State University and was on staff at Sinai Hospital. He retired from practice in 1971.

Samuel S. Sorkin, MD
Flint

Doctor Sorkin, a Flint physician, died April 27 at the age of 80. Doctor Sorkin received his medical degree from the University of Michigan Medical School in 1930. He served as Captain in the Army Medical Corps during World War II. Doctor Sorkin maintained his Flint medical practice for 40 years. He was a member of the American Medical Association, MSMS and the Genessee County Medical Society.

Mutual Memo

3

Risk-reducing records

Third in a series

TO: **Michigan physicians**

FROM: **Loss Prevention, Underwriting and Claims departments**

RE: **Increasing patient satisfaction; preventing claims**

Research on more than 6,500 MPMLC claims shows that comprehensive, accurate medical records are one of the keys to high-quality patient care and low-risk medicine.

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Sign all entries.

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Write down instructions, orders and prescriptions you give over the phone — in the office and at home. Keep a notepad and pen close by for documenting calls. Your office personnel also should note their phone conversations with patients.

Acknowledge all diagnostic reports.

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MEETINGS

MSMS, MSMS/A, AMA & MEDICAL ASSISTANTS

September 5-6 — AMA Council on Medical Service, "Increased Competition in Medicine: Effective Physician Responses," Westin O'Hare Hotel, Chicago, contact: Mark Stuart 1-800-621-8335.

September 10 — MSMS Board of Directors Meeting, MSMS headquarters, East Lansing, contact: William Madigan (517)337-1351.

September 15 — MSMS Auxiliary Board Meeting, MSMS Headquarters, East Lansing, contact: Viola Heins (517)337-1351.

September 17 — AMA Conference on Alternative Delivery and Financing Systems: Your Options and How to Evaluate Them. To be held in Dearborn, contact: AMA Practice Management Registrar (312)645-4958 (call collect).

October 15 — MSMS Public Affairs/Leadership Conference, Clarion Hotel, Lansing, contact: Sherry Wellman (517) 337-1351.

November 7-9 — Michigan Medical Assistants "Grand Affair," Amway Grand Plaza Hotel, Grand Rapids, contact: Caroline Rich, MSMS Headquarters, East Lansing (517)337-1351.

November 10 — MSMS Auxiliary Board Meeting, MSMS Headquarters, East Lansing, contact: Viola Heins (517)337-1351.

November 14 — AMA Conference on Alternative Delivery and Financing Systems: Your Options and How to Evaluate Them. To be held in Dearborn, contact: AMA Practice Management Registrar (312)645-4958 (call collect).

November 19 — MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, contact: William Madigan (517) 337-1351.

OTHER MEETINGS

September 11-12 — Sixth Annual Meeting of the Society for Public Health Education, Inc., Educational Center of Kellogg Biological Station, Hickory Corners, contact: Barbara Hawkins, Vice President, SOPHE, Kent County Health Department, 700 Fuller, NE, Grand Rapids 49503 (616) 774-3931.

September 13 — Michigan Society of Pathologists, Ann Arbor, contact: Viola Heins (517)337-1351.

September 24 — Michigan Association for Medical Education, University Club, East Lansing, contact: Viola Heins (517)337-1351.

September 26-28 — Michigan Chapter, American Academy o Pediatrics, Hilton Shanty Creek Bellaire, contact: P. Miles Tiernan, Executive Secretary, 32245 Hearthstone, Farmington Hills 48010 (313) 553-3646.

October 10 —Michigan Psychoanalytic Institute Second Annual Benefit presents "The Black Monk," Hilberry Theater, Wayne State University, contact: Kathleen Kunkel, 16310 West 12 Mile Road, Southfield 48076 (313)559-5855.

Roster Correction

The following physician was incorrectly listed in the 1986 *Roster* of members of the Michigan State Medical Society. The correct listing is as follows:

Samuel V. Srinivasan
830 S. Jefferson
Saginaw, MI 48601

The editor regrets any inconvenience the incorrect listing may have caused.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.
Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

Date: September 3, Update '86—Rehabilitation of the Closed Head Injured. Location: Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo, Michigan. **Sponsor:** Bronson Methodist and Bronson Vicksburg Hospitals. West Michigan Physiatry, PC and Southwestern Michigan Area Health Education Center. **Contact:** Marilynn Ley Rathbun, CRRN, Bronson Methodist Hospital, 252 E. Lovell St., Kalamazoo 49007 (616)383-7734. **Approved for:** 5.75 hours of Category I Credit and 5.75 hours of AAFP Credit.

Date: September 6, Basic Cardiac Life Support Course for Physicians. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Date: September 6-7, Chief Surgical Residents. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: September 7-8, Advanced Cardiac Life Support Provider Course. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School (313)763-1400. **Approved for:** 16 hours of Category I Credit.

Date: September 10, Medicine and the Law/Alternative Health Care Delivery Systems. Location: Schuler's Restaurant, Marshall. **Sponsor:** Southwestern Michigan Area Health Education Center and Albion Community Hospital. **Contact:** Continuing Medical Education, 4th Floor, Stryker Center, 1521 Gull Road, Kalamazoo, MI 49001 (616) 383-6360. **Approved for:** 6 hours of Category I Credit.

Date: September 11-13, Grand Rapids 17th Annual International Symposium on Implant Surgery for the Hand, Upper Extremity, and Foot. Location: Blodgett Memorial Center and Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** Michigan State University College of Human Medicine and International Federation of Societies for Surgery of the Hand. **Contact:** Alfred B. Swanson, MD, Blodgett Professional Building, Suite 290, 1900 Wealthy Street, SE, Grand Rapids 49506. **Approved for:** 18 hours of Category I Credit.

Date: September 12-13, Parenteral and Enteral Nutrition 1986: Clinical Update. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: September 12-13, Hypertension 1946-1986: The First Ann Arbor International Reunion. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: September 12-13, Recent Advances and Applications in Clinical Nutrition. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:**Betty Phillips, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, Michigan 48109-0010 (313)763-1400. **Approved for:** 9.5 hours of Category I Credit.

Date: September 13, A Potpourri of Practical New Developments in Gastroenterology. Location: South Macomb Hospital Auditorium, Warren. **Sponsor:** Detroit-Macomb Hospital Corporation. **Contact:** Department of Medical Affairs (313)821-6000 ext. 270. **Approved for:** 3 hours of Category I Credit.

Date: September 13-17, Tutorial on Level I Muscle Energy Technique. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: September 25-27, repeated November 13-15, Neonatal/Infant/Child Life Support. Location: Gilmore Health Education Center, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association and Southwestern Michigan Area Health Education Center. **Contact:** William H. Scott, MD, Southwestern Michigan Perinatal Association, 252 E. Lovell Street, Kalamazoo 49007 (313)383-6469. **Approved for:** 19 hours of Category I Credit.

Date: September 25-27, Diagnostic Ultrasound. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 15 hours of Category I Credit.

Date: September 26-28, American Academy of Pediatrics, Michigan Chapter 37th Annual Scientific Meeting. Location: Hilton Shanty Creek Summi Conference Center, Bellaire. **Sponso** Michigan Chapter, American Academy o Pediatrics. **Contact:** Mr. P. Miles Tiernan 32245 Hearthstone, Farmington Hill 48018. **Approved for:** 7 hours o Category I Credit.

Date: September 26-28, Tutorial on Leve I Myofascial Release Technique. Location Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and Colleg of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medica Education, MSU, A306 E. Fee Hall, Eas Lansing 48824 (517)353-9714. **Approved for:** 24 hours of Category I Credit

Date: September 27-28, Current Challenges and Physician Responses — Cardiology, Oncology, and Adolescent Medicine. Location: Burns Clinic Medica Center. **Sponsor:** Burns Clinic Foundatio and Burns Clinic Medical Center. **Contact** Kay Kelly, CME Coordinator, Burns Clinic 560 W. Mitchell, Petoskey 49770. **Approved for:** 12 hours of Category I Credit

Date: September 29-October 1 Hemodynamic Monitoring and Management Seminar. Location: Towsley Center Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbo 48109-0010 (313)763-1400. **Approved for:** 14 hours of Category I Credit.

Date: October 1-3, Mechanical Ventilatory Support and Management. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313) 763-1400. **Approved for:** 15 hours of Category I Credit.

Date: October 2-3, Diabetes Care. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 16 hours of Category I Credit.

Date: October 2-3, SIDS/Apnea—Medical Management of the Infant at Risk. Location: Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** SIDS/Apnea Research and Treatment Center; Ross Laboratories; Southwestern Michigan Area Health Education Center. **Contact:** Michael N. Musci, Jr., DO, Bronson Methodist Hospital, SIDS/Apnea Research and Treatment Center, 252 E. Lovell Street, Kalamazoo, MI 49007 (616)384-8484. **Approved for:** 5 hours of Category I Credit.

Date: October 3, 16th Annual Cardiology Symposium. Location: Kalamazoo Hilton Inn, Kalamazoo. **Sponsor:** Borgess Medical Center; Kalamazoo Chapter of the American Heart Association; Michigan Academy of Family Physicians. **Contact:** E. Enrique Leguizamon, MD, Borgess Med-

Continued on page 448

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ical Center, 1521 Gull Road, Kalamazoo 49001 (616)383-5930. **Approved for:** 6 hours of Category I Credit.

Date: October 3, Advances in Stroke Management. Location: Chelsea Community Hospital. **Sponsor:** MSMS Committee on CME Programming and Chelsea Community Hospital. **contact:** Debbie Buckmaster or Linda Visel (313)475-1311 ext. 403. **Approved for:** 6 hours of Category I Credit.

Date: October 4-5, National Conference for Chief Medical Residents. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)7631400. **Approved for:** 10 hours of Category I Credit.

Date: October 9-10, Ear, Nose and Throat Practicum. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Jolene Glaspie, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 17.25 hours of Category I Credit, 17.0 hours of AAFP credit.

Date: October 9-10, Ins and Outs of Critical Care: Fluids, Nutrition and Renal Management. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010, (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: October 11-15, Tutorial on Level II Manual Medicine Techniques (Above Diaphragm). Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: October 16-17, Perinatology and Neonatology. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Janet Boomer, Towsley Center, Box 0201, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 13.25 hours of Category I Credit.

Date: October 16-18, Common Surgical Problems in Childhood. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 18 hours of Category I Credit.

Date: October 18 & 25, The Basics of Searching Medline. Location: Bronson
Health Sciences Library, Kalamaz
Sponsor: Bronson Health Sciences Libr
Contact: Jeanne L. Hartenstein, Hea
Sciences Library, Bronson Methodist H
pital, 252 E. Lovell Street, Kalamazoo,
49007 (616) 383-6318. **Approved fo**
hours (both days) of Category I Cred

Date: October 19-23, Tutorial on Lev
Craniosacral Techniques. Location: K
logg Center, MSU. **Sponsors:** MSU Coll
of Osteopathic Medicine and College
Human Medicine. **Contact:** Sandy
bourn, Director of Continuing Medi
Education, MSU, A306 E. Fee Hall, E
Lansing 48824 (517)353-9714.
proved for: 40 hours of Category I Cre

Date: October 20-21, Care of the Eld
ly. Location: Towsley Center, Ann Arb
Sponsor: University of Michigan Medi
School. **Contact:** Anne Karolak, Tows
Center, Box 057, U-M Medical Scho
Ann Arbor 48109-0010 (313)763-00
Approved for: 12 hours of Categor
Credit.

Date: October 22, 3rd Annual Conf
ence on Alcoholism. Location: Gilm
Center for Health Education, Brons
Methodist Hospital, Kalamazoo. **Spons**
Kalamazoo Alcohol & Drug Abuse Co
cil; Southwestern Michigan Area Hea
Education Center; Gateway Villa; Ame
can Academy of Family Physicians. **Co**
tact: Charles L. Zeller, MD, 4th Flo
Stryker Center, 1521 Gull Road, Kalam
zoo, MI 49001 (616)388-7877. **A**
proved for: 6 hours of Category I Cred

Date: October 24-25, Advances in M
tidisciplinary Approaches in the Tre
ment of Cancer of the Breast, Head a
Neck, and Ovaries. Location: Towsl
Center, Ann Arbor. **Sponsor:** University
Michigan Medical School. **Contact:** An
Karolak, Towsley Center, Box 057, U-
Medical School, Ann Arbor 48109-00
(313)763-1400. **Approved for:** 10
hours of Category I Credit.

Date: October 24, Basic Cardiac Life Su
port Course for Physicians. Locatio
Towsley Center, Ann Arbor. **Sponso**
University of Michigan Medical Scho
Contact: Anne Karolak, Towsley Cente
Box 057, U-M Medical School, Ann Arb
48109-0010 (313)763-1400. **Approv**
for: 6 hours of Category I Credit.

Date: October 25, Advanced Cardiac Li
Support Course Recertification. Locatio
Towsley Center, Ann Arbor. **Sponso**
University of Michigan Medical Scho
Contact: Anne Karolak, Towsley Cent
Box 057, U-M Medical School, Ann Arb
48109-0010 (313)763-1400. **Approv**
for: 8 hours of Category I Credit.

Date: October 25, Coronary Artery Di
ease: Reducing the Risk and Treating th
Problem. Location: Livonia West Holid
Inn, Livonia. **Sponsor:**American Heart A
sociation. **Contact:Marilyn J. Veltma**
American Heart Association, 16310 W
12 Mile Road, P.O. Box 160, Lathrup V
iage, Michigan 48076 (313)557-950
Approved for: 6 hours of Category
Credit.

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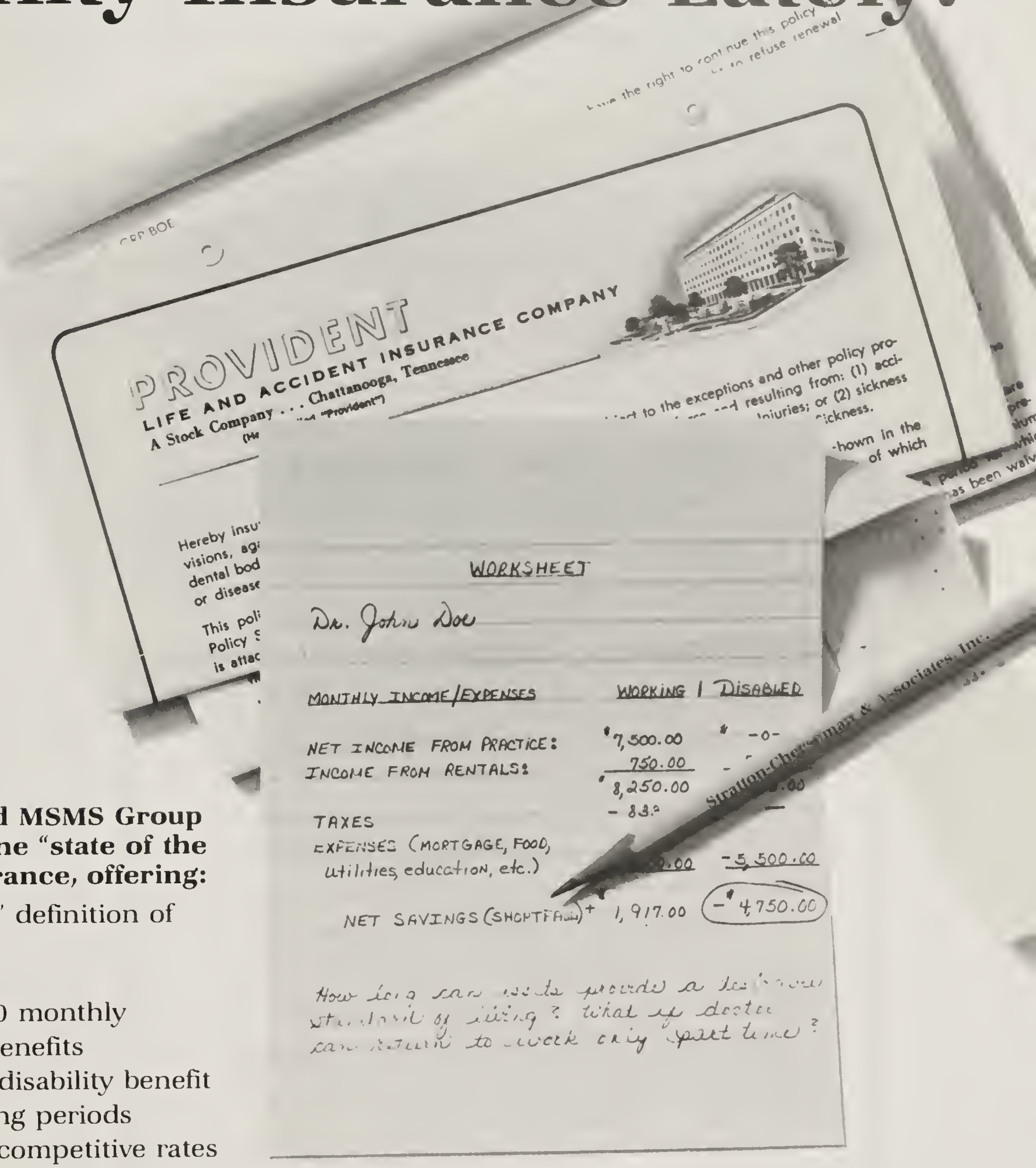
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Each of us can do more to solve liability problem

The medical liability crisis has been both a painful and healthy experience for physicians. It has been beneficial for our profession in that it has forced us to look within, and ask ourselves, "Can we do an even better job of caring for our patients?" During the year and a half of public debate on this issue, it has become obvious to all of us that real malpractice occurs. Confronting that fact has made us uncomfortable. But meeting that reality head-on has been, is, and will be, the key to our controlling our share of the problem.

Sure, studies conducted during the legislative review of our tort reform proposals confirmed that about 60 percent of medical liability claims are closed without payment to the plaintiff. But that's another problem—the litigiousness of society, greedy attorneys—whatever you want to call it. In any event, it's *outside* of our direct control.

We must continue to concentrate on the things we *can* control to maintain and improve patient satisfaction, and hence, prevent claims. Frankly, the most effective way we can reduce liability claims is to intensify our efforts to neutralize potential pitfalls in our individual practices.

As secretary-treasurer of Michigan Physicians Mutual Liability Company (MPMLC) and a member of its Claims Committee, I believe doctors have the power to eliminate most of the bona fide cases of malpractice.

Trouble spots

Our analyses of claims show that four areas of risk present the greatest trouble. We can develop strategies for eliminating liability claims by focusing on these categories in our daily practices:

- Communications: physician-patient, physician-physician and physician health professional. Studies repeatedly show that maximizing the quantity and quality of physician communication with patients promotes satisfaction with other medical care. Clear communication between physicians and health care professionals is essential to maintaining continuity in the quality of care. And many suits are started by physicians making casual judgmental remarks about other physicians' treatment.
- Medical record-keeping: Comprehensive, clear and accurate documentation of patient care is essential from both medical and legal viewpoints. The medical record is the most important base of objective information about a patient's health condition. Omissions and errors by healt care professionals can be fata Medical records also are a primary source of legal evidence in liability litigation. Cases are won and lost on the strength of the medical recor we keep.
- Shared responsiblity of health care professionals: We can be, and are, held liable fo the actions of those we supervise. Several physicians share responsibility for patient care in many cases. Ongoing professional dialogue is essential to foster the teamwork necessary to provide comprehensive patient care.
- Technical ability: I could recite a number of horror stories from the files. But suffice it to say that practicing beyond our depth, training or ability is frequently associated with liability claims.

In conclusion, we've learned that we, ourselves, can do more to minimize the medical professional liability problem. We know there are many flaws in our legal system, even with tort reform enacted. But the most responsible thing we, as physicians, can do is to continue to improve what we already do well—providing care for the well-being of our patients.☐

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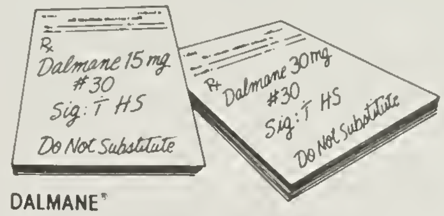

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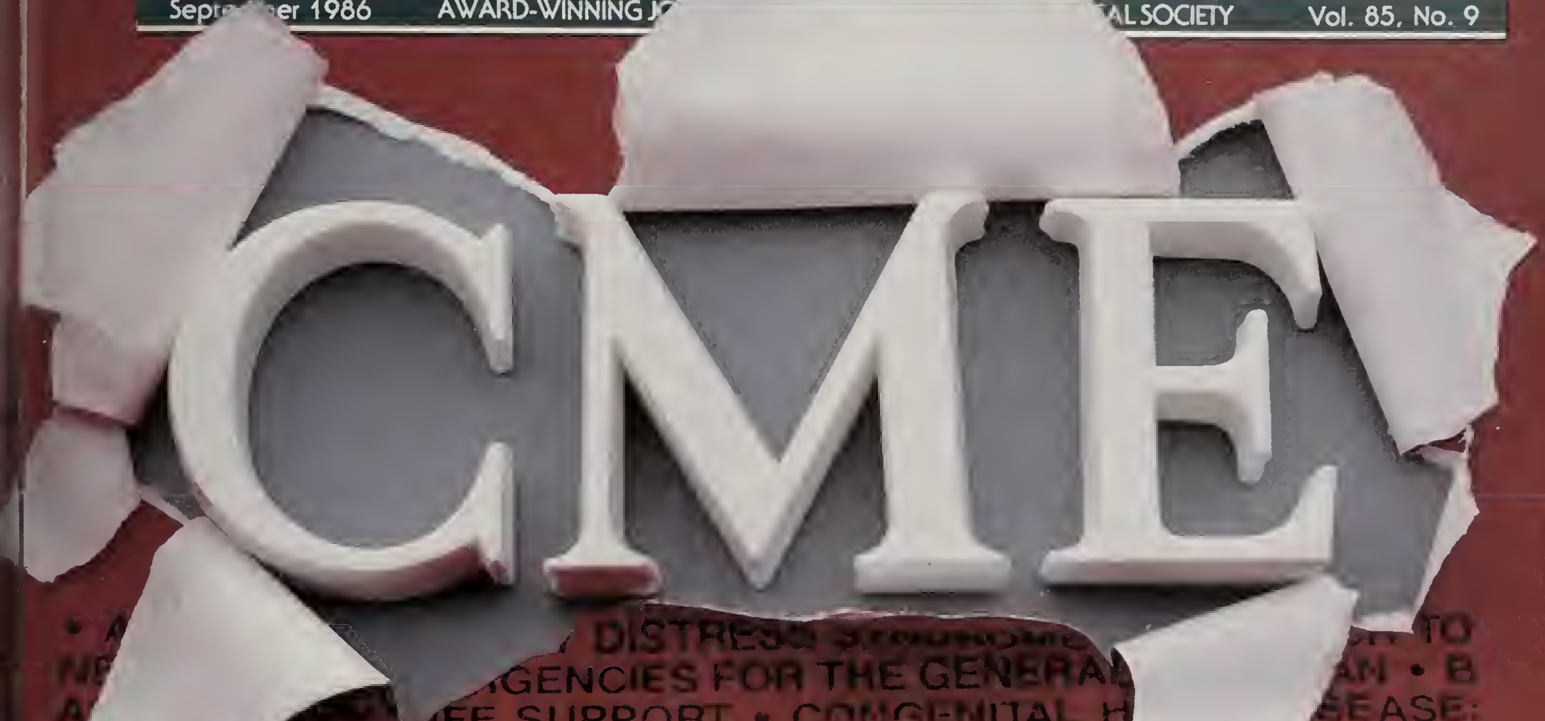
MICHIGAN MEDICINE

Sept er 1986 AWARD-WINNING JO AL SOCIETY Vol. 85, No. 9



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OF ACUTE MYOCARDIAL INFARCTION • DIABETES—A CURRENT
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Breakthroughs in medical care
1986 MSMS Annual Scientific Meeting
November 11-12-13

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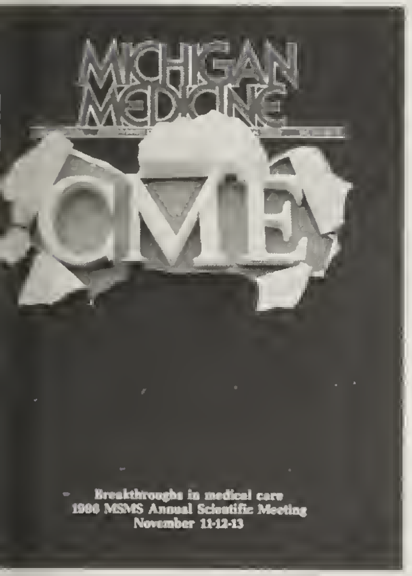
September 1985, Vol. 85, No. 9

MICHIGAN MEDICINE


MICHIGAN MEDICINE
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Breakthroughs in medical care
1986 MSMS Annual Scientific Meeting
November 11-12-13

bout the cover: This year's
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ake your plans now to at-
end the three-day meeting
ovember 11-12-13 at the
yatt Regency Dearborn.
hoto by Kim Kauffman.

next month's issue of
ichigan Medicine: The tan-
ible and intangible benefits
f MSMS membership will be
e subject of our October
pecial Report.

Special Report

457 Fifty-four courses featuring more than 200 expert speakers will address recent "Breakthroughs in Medical Care" at the 1986 MSMS Annual Scientific Meeting. Physicians can earn up to 18 hours of Category I credit during the three-day event at the Hyatt Regency Dearborn, November 11-12-13. Our Special Report offers course descriptions, a list of special events and a registration form, plus a special invitation to attend the meeting from Rudi Ansbacher, MD, meeting cochairman with Samuel McMahon, MD. Make plans now to attend.

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By Rudi Ansbacher, MD, MS

1986 MSMS Annual Scientific Meeting

ASM offers "breakthroughs"

Ansbacher

McMahon

The 121st Annual Scientific Meeting of the Michigan ate Medical Society will be eld November 11, 12 and 13, 986 at the Hyatt Regency earborn. This forum provides unique opportunity for the xchange of ideas among ose involved in patient care.

The Scientific Program Comittee has carefully selected pics that should appeal to hysicians in general as well as those in specialized pracces, and in medical and surgial fields. Our aim was to esent up-to-date and state-f-the-art subjects which would nhance the delivery of care to ur patients, and to familiarize urselves with topics that may erve as reviews to some but ill be new information to thers.

The Committee sought to esent some controversial ubjects by integrated faculties epresenting various portions f Michigan. We felt that this ould enhance the exchange f information between those private practice and those associated with academic institutions.

"Hot" topics

A careful perusal of the fifty-four topics picked for presentation over the three-day period should remind the attendee of the wide range of "hot" topics of current interest.

"*Bioethics: From Here to Eternity*" will be presented in a continuum each afternoon and will address such topics as the *Right to Die*, the *Baby Doe* issue, what to do for *patients who are incompetent* to decide upon appropriate therapy, and other issues we all are faced with in our daily practices.

The success of the "alpha-omega" courses given in 1985 encouraged us to have infectious diseases presented in such a format. Highlights will include "*Pediatric Infections*" on the first morning, "*Genitourinary Infections*" on the second morning, and "*Infectious Diseases of the Elderly and the Immunocompromised Patient*" on the third morning.

The "*Basic Cardiac Life Support*" course will again be presented each morning. Several highly successful courses from the 1985 meeting will be updated, including those on *diabetes*, *sports injuries*, *magnetic resonance imaging*, *immunology/allergy*, *gait problems* and *dermatology*.

New courses of general and specific interest will be those on *AIDS*, *somatization syndromes*, *breast malignancies*, *toxic substances*, *nutrition and exercise*, *critical care procedures*, and *electrolyte disorders*.

Other equally important topics round out the program to stimulate those attending. Adequate time for questions and answers will be provided as part of each course.

My sincere thanks go to the co-chairman of this meeting, Samuel M. McMahon, MD, who was most generous in his advice and guidance to the Committee in shaping this year's meeting. In addition I thank all the members of our committee: Frederick W. Bryant, MD; Michael Iacobellis, MD; Dorothy Kahkonen, MD; K.L. Krabbenhoft, MD; Nicholas J. Lekas, MD; Conrad E. Nagle, MD, and Joan C. Stryker, MD. Each of these physicians contributed their time and efforts to ensure that the 1986 meeting would be a successful one.

Finally, without the support of the staff of the Michigan State Medical Society, especially Sherry L. Fent, our efforts would have been unsuccessful.

I invite each and every one of you to attend the 1986 MSMS Annual Scientific Meeting and look forward to incorporating your suggestions into future programs.☐

---

octor Ansbacher is co-chairman, 986 MSMS Scientific Program ommittee. Samuel M. McMahon, D, is co-chairman as well.

At-a-glance schedule of special events

Tuesday, November 11	7:30 AM	Great Lakes Exhibit Center Open
	12 Noon	Luncheon/Board Meeting Michigan Occupational Medical Association
	12 Noon	Luncheon/Meeting Michigan Society of General Surgeons
	1:00 PM	Meeting Michigan Chapter, American College of Emergency Physicians
	3:30 PM	Poster Session and Reception
	5:30 PM	Board Dinner Meeting Michigan Society of Anesthesiologists
	5:30 PM	Reception/Dinner Michigan Society of General Surgeons
	6:00 PM	Open Reception "Meet the Dean" University of Michigan Medical School
	6:00 PM	Reception/Dinner Michigan College of Nuclear Medicine Physicians
	6:00 PM	Reception/Dinner Michigan Occupational Medical Association
Wednesday, November 12	7:30 AM	Great Lakes Exhibit Center Open
	9:00 AM	Meeting/Luncheon Michigan Allergy Society
	11:30 AM	Luncheon Seminar Michigan Psychiatric Society Committee on Women's Issues
	12 Noon	Luncheon Specialty Society Presidents
	3:00 PM	Board Meeting Michigan Orthopaedic Society
	5:30 PM	Business Meeting Michigan Otolaryngological Society
	6:00 PM	Reception and Dinner Michigan Orthopaedic Society
	6:00 PM	Reception and Dinner Michigan Otolaryngological Society
	6:00 PM	Board Meeting Michigan Physicians Mutual Liability Company
	6:00 PM	Reception/Cash Bar Michigan State University College of Human Medicine
	6:00 PM	Reception Wayne State University Medical Alumni
	6:30 PM	Reception and Dinner MSMS Exhibit Advisory Committee
Thursday, November 13	7:30 AM	Great Lakes Exhibit Center Open
	7:30 AM	Women Physician's Breakfast Sponsored by the MSMS Committee on Concerns of Women Physicians
	6:30 PM	Reception and Dinner Michigan Society of Colon and Rectal Surgeons

Alexander

Argenta

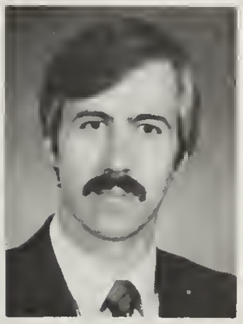
Baker

Bender

Bitterman

Bove

Breiner


Brickner

Brody

Chodorkoff

Coran

Daly

Choose from 54 Category I courses . . .

Tuesday morning November 11 All courses run from 8:30 to noon with half-hour break

■ Adult Respiratory Distress Syndrome

Lectures and presentation of related case material will provide participants with information about the pathophysiology, clinical presentation and management of this complex and potentially devastating critical illness.

COURSE DIRECTOR: Robert E. Klimek, MD, Lansing

■ Approach to Neurologic Emergencies for the General Physician

This course is designed for all doctors who must see acute neurological problems in an outpatient setting. There will be special emphasis on physical examination and its relationship to basic neuroanatomy and physiology. These principles will be expanded to discuss stupor, coma, and alterations of mental status.

COURSE DIRECTOR: Gregory L. Henry, MD, Ann Arbor

■ Basic Cardiac Life Support

The course will include lectures and practical stations for teaching Basic Cardiac Life Support. The practical session will include hands-on teaching of cardiopulmonary resuscitation, obstructed airway in an unconscious and conscious victim, as well as CPR and conscious and unconscious airway obstruction for an infant.

COURSE DIRECTOR: Robert K. Orr, Jr., DO, Lansing

■ Congenital Heart Disease: An Update

This course will provide an update on the management of basic congenital heart lesions for the pediatrician and primary physician. Through a series of half-hour lectures the following topics will be covered: fetal diagnosis, new operations for congenital heart lesions (including transplantation), balloon angioplasty, recommendations for sports activities before and after surgical treatment and pacemaker management in children. Current diagnostic techniques, indications and timing for surgery and late results into adolescence will be reviewed.

COURSE DIRECTOR: Edward L. Bove, MD, Ann Arbor

■ Current Management of Colorectal Malignancies

The combined incidence of carcinomas of the colon and rectum are second only to malignant neoplasms of the lung. One hundred forty thousand

Continued on next page

Ditmars

Elkins

Fekety

Fernandez-Madrid

Fisher

Freitas

Harrison

Henry

Ho

Honet

Jacknow

Kemink

TUESDAY MORNING/Continued

new cases are estimated for 1986 by the ACS and 60,000 deaths are estimated in 1986. This course will discuss the importance of risk factors including family history, history of inflammatory disease, diet and industrial exposure. The role and indications of early detection by out-patient procedures, such as digital rectal examination, stool studies and colonoscopy will be described. Indications for various treatment options including surgery only, plus surgery and radiation therapy will be described including results. The role of chemotherapy will be discussed.

COURSE DIRECTOR: Harold Perry, MD, Detroit

■ **Pediatric Infectious Diseases** (Alpha-Omega Part 1)

This course, planned as the first of a three-part "alpha-omega" session on infectious diseases, will provide primary physicians with a review of current childhood infectious disease issues. Through a combination of 35-minute lectures and 10-minute discussions, the speakers will address how to diagnose and manage children with AIDS, hepatitis B, herpes simplex, and respiratory infections. Current concepts and issues of preventing infectious diseases through immunization and antiviral chemotherapy will also be considered. Emphasis will be placed on new developments in diagnosis, treatment and prevention of childhood infections. On Wednesday and Thursday mornings, there will be two more courses on infectious disease in the mid-years and in the elderly.

COURSE DIRECTOR: Thomas C. Shope, MD, Ann Arbor

■ **Rediscovered Epidemics in the Work Place**

This course is designed for both occupational physicians and the private treating physicians who are frequently faced with work-related problems secondary to continuous physical exposures and who have a need to learn to recognize and respond to such problems. In this session, two apparently dissimilar sets of problems will be presented which are common causes of disability intensities. As a counterpoint to this, a medical health and safety specialist will present labor's viewpoint on aspects of cumulative trauma.

COURSE DIRECTOR: David Jacknow, MD, Southfield

■ **The Multimodality Treatment of Breast Cancer**

The aim of this course is to u date the primary physician, internist, surgeon, pathologist and radiologist in the multimodality approach to the diagnosis and treatment of breast cancer. Through a series of 30 minute lectures, the interactio of the five disciplines that manage breast cancer patients will be discussed. The organization of a multidisciplinary breast clinic will be outlined, and the impact of new legislation concerning what a patien must be told about treatment options will be highlighted.

COURSE DIRECTOR: Allen S. Lichter, MD, Ann Arbor

■ **Therapy of Acute and Chronic Intoxication**

In this course, we will discuss the current management of acute and chronic intoxication including that seen from alcohol, prescription drugs, street drugs and a mixture of the above. Workup for therapy of the acute reaction as seen in the E.R. as well as therapy for the chronic phase including withdrawal will be discussed.

Klimek

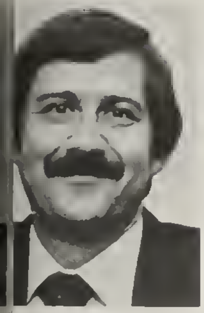
Lawson

Lichter

Lucas

Martel

McGillicuddy


Migdal

Penner

Perlman

Perry

Royer

Seaman

OURSE DIRECTOR: George L. oyer, Jr., MD, Kalamazoo

Tuesday afternoon November 11

All courses run from 1:30 to 5 pm with half-hour break

Special Event

Clinical poster displays will be set up in the Great Lakes Exhibit Center beginning at 3:30 Tuesday afternoon. At the end of the courses, the authors will be available to discuss their posters. Beer, soft drinks and snacks will be served as part of this session.

■ Bioethics: From Here to ternity (Part 1)

his course, the first of a hree-part session on bioethics, vill explore ethical problems rising during infancy, childood and adolescence. The ormat will consist of brief resentation, case discussions nd role playing as a member f a hospital ethics committee. Specific problems to be considered include withholding and withdrawing treatment from newborns with disabilities and very low birth weight infants; the validity of parental consents; the adolescent, autonomy, and confidentiality; and related issues. On Wednesday and Thursday afternoons there will be two more courses on bioethical issues as they relate to the middle-aged and the elderly.

COURSE DIRECTOR: William B. Weil, Jr., MD, Lansing

■ Critical Care Procedures for Primary Care Physicians

The emphasis of this course will be placed on new procedures or novel variations of well-known procedures. For example, the recently introduced Cook catheter for treatment of pneumothorax is a small bore catheter which may be easily inserted by the primary care physician in an emergency situation. Other areas to be covered include endotracheal intubation, emergency tracheostomy, and cricothyroidotomy, central and arterial vascular access, pericardiocenthesis and temporary pacemaker insertion, and critical care laboratory procedures.

COURSE CO-DIRECTORS: Lyle D. Victor, MD, and **Nicholas Lekas, MD,** Dearborn

■ Evaluation & Management of the Confused Elderly Patient

Many elderly patients develop confusion and it is not always possible to decide whether the cause is medical or psychiatric. This course is designed to enable the physician faced with such a problem to make a rational judgment. The course will be presented by a psychiatrist, neurologist, family physician and a social worker. Specific areas to be dealt with will include: a) the neurological, psychiatric and drug induced causes of confusion; b) the use of social and family resources in the management of such patients, and c) appropriate medical management of such patients. The format will include didactic presentation, a panel discussion and will provide for the discussion of clinical problems in a small group setting.

COURSE DIRECTOR: Sumer Verma, MD, East Lansing

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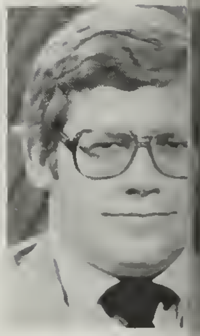
Shope

Sobel

Sokol

Sowers

Stryker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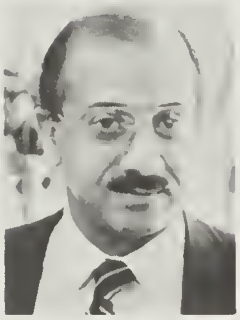
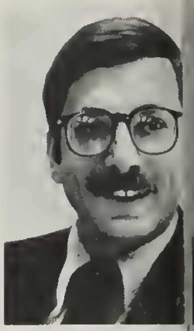

Verma

Victor

Walt

Weil

Williamson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Register for courses on page 470

TUESDAY AFTERNOON/Continued

■ Osteoporosis 1986: A Silent Epidemic

A three-hour course in pathophysiology, diagnosis and therapy of osteoporosis. Identification of risk factors, differential diagnosis, proper use of dual photon absorptimetry scanning, estrogen use (when and how much), calcium supplementation (when and how much), and the role of exercise will be discussed.

COURSE CO-DIRECTORS: Malcolm E. Williamson, DO, Trenton, and **Milton Gross, MD,** Ann Arbor.

■ Perioperative Management of the High-Risk Surgical Patient

This course will provide practical information on how to manage the four most common disease entities that markedly increase a patient's operative risk. Through a combination of 30-minute lectures and a discussion period, the preoperative preparation and the postoperative management of the patient with diabetes, hypertension, chronic lung disease and coronary artery disease will be outlined.

COURSE DIRECTOR: Gaylord D. Alexander, MD, Detroit

■ Somatization Syndrome

Some of the many medical/surgical problems that will be explored are dyspareunia, vaginismus, ICU and postoperative mental symptoms, non- compliance, inability to get well, persistent pain, depression equivalents, and the uncooperative and/or angry patient. Many psycho-physiological clinical problems will be presented. Application of this increased knowledge to everyday clinical cases and the management of the "difficult" patient will be stressed.

COURSE DIRECTOR: Sander J. Breiner, MD, FAPA, Birmingham

■ What's New in Surgical Oncology

This course will present current views and new aspects of different malignant diseases a they affect the surgeon or referring physician.

COURSE DIRECTOR: Charles
Lucas, MD, Detroit

Wednesday morning November 12
All courses run from 8:30 to noon with half-hour brea

■ Basic Cardiac Life Support

The course will include lectur and practical stations for teaching Basic Cardiac Life Support. The practical session will include hands-on teachin of cardiopulmonary resuscitation, obstructed airway in an unconscious and conscious vi tim, as well as CPR and conscious and unconscious airway obstruction for an infant.

COURSE DIRECTOR: Robert K. Orr, Jr., DO, Lansing

■ Blood: Its Use and Abuse

his course provides clinicians
vith an overview of blood
ransfusion therapy. Through a
ombination of half-hour lec-
ures, current trends in effec-
ive utilization of blood
roducts, their monitoring by
ne hospital transfusion com-
nittees and role of autologous
onor programs will be cov-
red. Management of febrile
ansfusion reactions using
nodified blood products will
e discussed along with the
sk of transfusion-associated
IDS and hepatitis. Michigan's
lood supply and issues facing
ne blood centers will be ad-
ressed.

**OURSE DIRECTOR: Shobha L.
hah, MD,** Detroit

■ Controversies in Manage-nent of Acute Myocardial nfarction

his course will provide an in-
roduction and overview of the
ssues involved in the interven-
ionally oriented management
f acute MI, including presen-
ations on tissue type plas-
ninogen activator, acute
ngioplasty and general anes-
hesia. We will also include
iscussions on secondary pre-
ention, including the effect of
eta-blockers and calcium
hannel blockers.

**OURSE DIRECTOR: Joshua
Vynne, MD,** Detroit

■ Diabetes—A Current linical Overview

his course will be clinically
riented covering Type I and
ype II diabetes and complica-
ons. We will discuss new ad-
ances on the horizon. Ade-
uate time will be allowed for
uestions and answers, as well
s for individual consultations.

**OURSE DIRECTOR: George L.
oyer, Jr., MD,** Kalamazoo

■ Genitourinary Infections
lpha-Omega Part 2)

he course planned as the sec-
nd of a three-part "alpha-omega" session on infectious diseases is designed to bring primary care physicians of all disciplines up-to-date with recent clinical advances in ambulatory diagnosis and management of urinary tract infections, vaginitis and cervical infections, including those caused by Chlamydia and Herpes Simplex Genitalis. On Thursday morning, another course will be presented dealing with infectious diseases in the elderly.

COURSE DIRECTOR: Jack D. Sobel, MD, Detroit

■ Peripheral Nerve Injuries

This course will provide an overview of the diagnosis and treatment of peripheral nerve injuries. Using both lecture and case presentation formats, the steps outlined in the initial diagnosis of peripheral nerve injuries, the immediate care and operative repair of such injuries and the electromyographic findings of acute and chronic nerve injuries will be reviewed. Attention will be paid to combined peripheral nerve and tendon injuries and the factors to be weighed in both diagnosis and treatment of these injuries. The lecture will also focus on the rehabilitation of patients with peripheral nerve injuries, including modalities of physical therapy, tendon and muscle transposition and prosthetic devices.

COURSE DIRECTOR: John E. McGillicuddy, MD, Ann Arbor

■ Principles of Psychotherapy

This course is provided for psychiatrists and other physicians who wish to improve their understanding of the process of psychotherapy and its applications. The course will be divided into: 1) Introduction to dynamic psychotherapy; 2) Getting the process underway; 3) The "working through" process, and 4) Termination: What does it mean to the patient? How does the therapist manage this?

COURSE DIRECTOR: Bernard Chodorkoff, MD, PhD, Detroit

■ Recognizing and Understanding Toxic Substance Exposures

This course will provide the primary physician, through one-half hour presentations, a review of the occurrence and significance of the real and potential hazards of exposure to toxic substances in the environment. It will outline the possible short and long-term health effects that exist in light of present knowledge and review the state of the art in environmental health risk assessment. The resources and assistance that are available to the physician in assessing the need for patient management and follow-up care will be covered as well.

COURSE DIRECTOR: James T. Harrison, MD, Lansing

■ Sexual Dysfunction Secondary to Cancer and Cancer Treatment

This course will provide practical information regarding frequency, pathophysiology, and proposed intervention strategies regarding sexual dysfunction secondary to cancer and cancer treatment. As cancer treatment becomes more successful in terms of survival outcome, sexual dysfunction is becoming an increasingly disturbing secondary effect. Physicians continue to be concerned with quality of life issues as well as "therapeutic successes."

COURSE DIRECTOR: Laurence H. Baker, DO, Detroit

■ Sports Injuries in Primary Care

This course will review injuries of the brain, spine, peripheral nerves and joints. Designed as an integrated course, participants will learn to diagnose and treat the wide range of

Continued on next page

sports injuries seen in the pediatric and adult age groups.

COURSE DIRECTOR: Robert E.M. Ho, MD, Troy

Wednesday afternoon November 12

All courses run from 1:30 to 5 pm with half-hour break

■ Bioethics: From Here to Eternity (Part 2)

This course, the second of a three-part session on bioethics, will consist of three or four segments focusing on obstetric and gynecologic issues. The subjects to be included are 1) ethical concerns in the new reproductive technology, including in vitro fertilization and surrogate parenting; 2) issues related to maternal/fetal conflict, such as fetal therapy and forced Caesarean section; 3) ethical concerns as they relate to the current liability crisis, and 4) contraceptive counseling for teenagers. These topics will be presented in a small group discussion format. On Thursday afternoon, another course will be presented on bioethical issues as they relate to the elderly.

COURSE DIRECTOR: Thomas E. Elkins, MD, Ann Arbor

■ Clinical Applications of Magnetic Resonance Imaging: Update

This is a new and important non-invasive imaging modality which does not require ionizing radiation or contrast agents. It is an extremely sensitive indicator of the presence and extent of disease and has been shown to be particularly valuable in a variety of neurologic conditions. More recently, attention has been turned to its use in a number of other diseases affecting the mediastinum, abdomen, pelvis, musculoskeletal, and cardiovascular systems. The current role of MRI in various clinical situations, comparing it with other diagnostic modalities, will be demonstrated. Indications and contraindications will be discussed. MRI is already changing some approaches to diagnosis.

COURSE DIRECTOR: William Martel, MD, Ann Arbor

■ Infectious Diseases of the Head and Neck

This course will cover the diagnosis and management of a variety of pediatric and adult otolaryngologic infections. Common infections, as well as much less frequently occurring infections and opportunistic infections involving the head and neck regions will be discussed.

COURSE CO-DIRECTORS: Michael J. Sullivan, MD, and **John L. Kemink, MD,** Ann Arbor

■ Keeping Current in Office Gynecology

This course will provide primary physicians with current information on three frequent problems. 1) Contraception: What are the options since the IUD is "off" the market? What may be considered safe contraception for the 30-45 year-old woman. 2) Menopause: How to detect and treat the menopausal syndrome including detection, prevention and/or treatment of osteoporosis. Should all women receive estrogen replacement therapy? 3) Urinary Incontinence: Methods to assist in making the right diagnosis for institution of the appropriate therapy in menopausal women.

COURSE DIRECTOR: Robert J. Sokol, MD, Detroit

■ New Directions & Controversies in Treatment of Cancer of the Breast and Prostate

Cancer of the breast and prostate are the most frequen malignancies the practicing physician will encounter, and can be expected to occur in 1 percent of the female and male population, respectively. The course will address new hormonal agents presently offered for management of prostatic cancer in relation to the standard surgical and chemotherapeutic approaches. Breas cancer will be discussed in terms of new variations in surgical approaches as well as controversies related to adjuvant chemotherapy.

COURSE DIRECTOR: John A. Penner, MD, Lansing

■ New Techniques in Genetics for Prenatal Diagnosis

This course will present the methodologies for using recombinant DNA techniques i prenatal diagnosis. The important limitations of these techniques, since they utilize linke markers and do not study the abnormal gene, will be discussed. Their use in Duchenne muscular dystrophy and cystic fibrosis will be illustrated. Other advances, such as the meaning of low maternal serum alpha fetoprotein, will also be discussed.

COURSE DIRECTOR: Robert P. Erickson, MD, Ann Arbor

■ Optimal Management of the Thyroid Patient

This course will provide the primary care physician with a review of the management of common thyroid problems and the interpretation of thyroid function tests. Thyroid nodules, hyperthyroidism, hypothyroidism and misleading lab tests will be emphasized. At the completion of the course, the attendee should be able to properly diagnose, manage, and know when to refer pa-ents with thyroid disease.

OURSE DIRECTOR: John E. reitas, MD, Royal Oak

Sexual Myths and erversions

his course for primary care hysicians is clinical and prac- cal in its presentation of iany common problems, such s: voyeurism, exhibitionism, ansvestism, transexuality, omosexuality, sadism, maso- iism, fetishism, many sexual artners, mental pain with sex, npotence, frigidity, pedo- hilia, teen deviant sexuality, nd many myths including the right partner.'' Diagnosis, dy- amics, and treatment tech- ques will be elucidated. Sex- al fantasies and pornography ill be explored, along with mphomania and satyriasis.

OURSE DIRECTOR: Sander J. reiner, MD, FAPA, Bir- ingham

Update in Immunology/ llergy

his course will provide pri- ary physicians and allergists ith a review of recent ad- nces in the diagnosis and anagement of stinging insect nsitivity, the management of munodeficiency disorders nd newer diagnostic tests sed in evaluating the patient ith suspected allergic dis- ders.

OURSE DIRECTOR: David Sea- an, MD, Canton

What's New In ermatology

ne course will provide an up- ate on new diseases, therapy, agnostic methods and prog- osis. Approximately one-third ill be devoted to cutaneous rgery and the remainder of e course to medical care. ectures will be divided into irty-minute segments with ve minutes for questions and nswers. The information will e suitable for dermatologists, ediatricians, internists, family ractitioners and similar health care professionals.

COURSE CO-DIRECTORS: James E. Rasmussen, MD, and **Neil A. Swanson, MD,** Ann Arbor

Thursday Morning November 13 All courses run from 8:30 to noon with half-hour break

■ Basic Cardiac Life Support

The course will include lectures and practical stations for teaching Basic Cardiac Life Support. The practical session will include hands-on teaching of cardiopulmonary resuscitation, obstructed airway in an unconscious and conscious victim, as well as CPR and conscious and unconscious airway obstruction for an infant.

COURSE DIRECTOR: Robert K. Orr, Jr., DO, Lansing

■ Common Pediatric Surgical Problems

This course will deal with common surgical problems encountered in children. Specifically it will deal with pediatric trauma, abdominal pain and solid malignancies.

COURSE DIRECTOR: Arnold G. Coran, MD, Ann Arbor

■ Cosmetic Surgery

This course is directed towards plastic surgeons with presentations of advanced and newer techniques in cosmetic surgery. Technical details will be presented to course participants who are presumed to be very familiar with the basic procedures. Richard Mladick, MD, a prominent teacher in the field of suction lypolysis, will discuss his experience in various areas of body contouring. Problems of eyelid and breast cosmetic procedures with their prevention and correction will be presented.

COURSE DIRECTOR: Donald M. Ditmars, Jr., MD, Detroit

■ Gait-Way to Successful Diagnosis

This course will provide primary care physicians with practical information about gait problems in adult patients which will be helpful in analysis and diagnosis of the problem. The course will utilize a live model for demonstration of the physical examination of gait and will utilize live patient demonstrations for abnormal gait patients seen in the course of a medical practice.

COURSE DIRECTOR: Joseph C. Honet, MD, MS, FACP, Detroit

■ Infectious Diseases in the Elderly and Immunocompromised Patient

This course will present current management of serious and also uncommon infectious problems in elderly or compromised hosts. Emphasis will be on pneumonia, skin infections, diarrhea and candidiasis.

COURSE DIRECTOR: F. Robert Fekety, Jr., MD, Ann Arbor

■ Non-Articular Rheumatism

This course, intended for the primary physician and general internist, will review the diagnosis and management of common problems usually labeled as ''non-articular rheumatism,'' such as the overuse syndromes. Emphasis will be on the lower extremities, common conditions involving the upper extremities with emphasis on the shoulder, low back pain and the painful foot.

COURSE DIRECTOR: Felix Fernandez-Madrid, MD, Detroit

■ Nutrition and Exercise

This course will discuss nutrition and exercise, including

Continued on next page

current controversies, and the interrelationships which maintain good health. Certain hazards associated with exercise, such as acute cardiovascular incidents, injuries, amenorrhea and osteoporosis will also be discussed. The field of biomechanics has made us aware of the forces that are generated by different types of exercise and how the body can be controlled to avoid many injuries.

COURSE DIRECTOR: Miriam S. Daly, MD, Albion

■ Role of Nutrients in Blood Pressure Control

This course, through a combination of four 40-minute lectures, will provide both the internist and primary physician with a current review of the role of nutrients in both the pathophysiology and treatment of essential hypertension. We will review the roles of sodium, calcium, obesity and chronic occult lead ingestion in hypertension. Special emphasis will be given to concerns in the elderly and black population.

COURSE CO-DIRECTORS: James R. Sowers, MD, and **Steven M. Gualdoni, PA-C,** Detroit

■ The Silent Danger: Recognizing and Managing Closed Head Injury

Up to 20,000 closed head injuries occur in Michigan every year. In this program participants will learn to identify clinical and behavioral symptoms of closed head injury and list strategies for medical intervention, referral, and interdisciplinary rehabilitation.

COURSE DIRECTOR: Leonard F. Bender, MD, Detroit

Thursday afternoon November 13

All courses run from 1:30 to 5 pm with half-hour break

■ Advances in Plastic and Reconstructive Surgery-1986

Reconstructive surgery has become a rapidly changing and evolving field with multiple new techniques emerging within the past several years. The fields to be covered include microsurgery and replantation, tissue expansion, lasers in surgery, craniofacial surgery, and facial reanimation.

COURSE DIRECTOR: Louis C. Argenta, MD, FACS, Ann Arbor

■ AIDS Update

This course will familiarize practicing physicians with the psychological and social aspects of diagnosing and treating AIDS patients and will provide an update on current research and data on AIDS nationally and in Michigan. It will also provide participants with information on community resources and activities regarding AIDS, to enable them to take a more active role in community efforts.

COURSE DIRECTOR: Evelyn J. Fisher, MD, Detroit

■ Bioethics: From Here to Eternity (Part 3)

This third portion of "Bioethics: From Here to Eternity" will focus on ethical issues arising in the later years of life. Updates on issues arousing recent controversy will be presented. Topics that will be addressed include advance directive ("living will") legislation in Michigan and around the country; withholding food and fluids, and the impact of cost containment on quality of care in the elderly. Other courses on bioethical issues as they relate to pediatrics and the mid-years are offered on Tuesday and Wednesday afternoons.

COURSE DIRECTOR: Howard A Brody, MD, East Lansing

■ Carcinoma of the Breast

Carcinoma of the breast presents many problem areas which need to be discussed even though definitive answers may not yet be available. Such areas include: 1) the different prognosis of some of the less common histological types, e.g., mucoid carcinoma, medullary carcinoma, cystosarcoma phyllodes; 2) The situation in context of carcinoma in situ which has been increasingly recognized as more and more screening mammography is done; 3) Carcinoma of the breast in the young and the pregnant; 4) the place of neoadjuvant chemotherapy, especially pertaining to inflammatory carcinoma and State III carcinoma; 5) The current status of reconstruction of the breast, whether immediate or delayed, 6) What advice to give regarding estrogen and progestational agents.

COURSE DIRECTOR: Alexander J. Walt, MD, Detroit

■ Common Anorectal Problems

The purpose of this course is to provide practical information about common anorectal problems through a series of lectures designed both for the primary care physician and specialists interested in anal pathology. The topics to be discussed include hemorrhoids, fistula-abscess, anal fissure, and pruritis ani. The common conservative and surgical treatments will be discussed, as well as some of the modern

Continued on page 46

DIMENSION III

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Now there's a new low-cost health care plan for Michigan State Medical Society members and their employees. It's Dimension III from Blue Cross and Blue Shield of Michigan... a health care plan in which the subscriber shares in the cost of the covered services. Dimension III is a lower cost alternative to the other health care plans presently available to doctors and their employees. Here's how the plan works.

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trends in treatment.

COURSE DIRECTOR: Robert J. Brickner, MD, Lansing

■ Essentials of Acid Base and Fluid and Electrolyte Disorders

This course will provide the practicing physician with a practical overview of the current concepts in the pathogenesis, diagnosis and management of patients with metabolic acidosis, alkalosis and disorders of hypo and hypernatremia. The final lecture will present a concise update of the status of renal transplant in the therapy of patients with end stage renal disease. The role of newer immunosuppressive agents also will be discussed.

COURSE DIRECTOR: Stephen D. Migdal, MD, FACP, Detroit

■ Food Poisonings, Carbon Monoxide Intoxication and Anaphylaxis

The intent is to provide practical, interesting information by way of case presentations, lectures, and audience participation. The first hour will review the recognition and pathophysiology of the common "food poisoning" syndromes. A handout of clinical problems and answers will be provided. The second hour will cover the diagnosis and management of carbon monoxide poisoning. The last hour will review the emergency treatment of acute allergic reactions and anaphylaxis.

COURSE DIRECTOR: Robert A. Bitterman, MD, FACEP, Ann Arbor

■ Peripheral Vascular Diseases

Participants in this course, through a combination of half-hour lectures and a panel discussion, will review the noninvasive evaluation of the ischemic lower extremity, revascularization and levels of amputation; physiatric evaluation and treatment regarding rehabilitation of the amputee; specific physical therapy intervention including energy cost of prosthetic ambulation. They also will hear of new changes in prosthetic design and components.

COURSE DIRECTOR: Owen Z. Perlman, MD, Ann Arbor

■ Quality Control for the Office Laboratory

The course is intended for physicians in whose offices laboratory tests are being performed. Through a series of 30- and 45-minutes lectures supplemented by handout material, the participants will receive information on general aspects of clinical laboratory testing in the office environment, assurance of quality, regulatory aspects of testing, and professional external quality control provided through organized medicine. The participants will become familiar with opportunities, limits and responsibilities associated with office laboratory testing

COURSE DIRECTOR: Noel S. Lawson, MD, Detroit

Register early and win!

Win a complimentary room for two nights and dinner for two at Giulio & Sons by making your Annual Scientific Meeting room reservations early!

To be eligible for the **October 21** drawing, simply make your reservation prior to **October 17.** Room reservations must be made *direct* with the Hyatt Regency Dearborn Reservations Office, Fairlane Town Center, Dearborn, MI 48126. Telephone number of Hyatt Dearborn Hotel is (313) 593-1234. Indicate that you are attending the MSMS Annual Scientific Meeting to take advantage of the convention rate. Remember . . . after **October 17** rooms are on an availability basis only.

Registration form on page 470.

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1986 MSMS Annual Scientific Meeting, Hyatt Regency Dearbo
Registration form for Category I CME Courses

***All courses are approved for AAFP Prescribed Credit EXCEPT those marked with an asterisk.**

TUESDAY MORNING, NOV. 11
(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

___ Adult Respiratory Distress Syndrome
___ Approach to Neurologic Emergencies for the General Physician
___ Basic Cardiac Life Support
___ Congenital Heart Disease: An Update
*___ Current Management of Colorectal Malignancies
___ Pediatric Infectious Diseases (Alpha-Omega Part I)
___ Rediscovered Epidemics in the Work Place
___ The Multimodality Treatment of Breast Cancer
___ Therapy of Acute and Chronic Intoxication

TUESDAY AFTERNOON, NOV. 11
(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

___ Bioethics: From Here to Eternity (Part I)
___ Critical Care Procedures for Primary Care Physicians
___ Evaluation & Management of the Confused Elderly Patient
___ Osteoporosis 1986: A Silent Epidemic
*___ Perioperative Management of the High-Risk Surgical Patient
___ Somatization Syndrome
*___ What's New in Surgical Oncology

WEDNESDAY MORNING, NOV. 12
(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

___ Basic Cardiac Life Support
___ Blood: Its Use and Abuse
___ Controversies in Management of Acute Myocardial Infarction
___ Diabetes — A Current Clinical Overview
___ Genitourinary Infections (Alpha-Omega Part 2)
*___ Peripheral Nerve Injuries
___ Principles of Psychotherapy
___ Recognizing and Understanding Toxic Substance Exposures
___ Sexual Dysfunction Secondary to Cancer and Cancer Treatment
___ Sports Injuries in Primary Care

WEDNESDAY AFTERNOON, NOV. 12
(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

___ Bioethics: From Here to Eternity (Part 2)
___ Clinical Applications of Magnetic Resonance Imaging: Update
___ Infectious Diseases of the Head & Neck
___ Keeping Current in Office Gynecology
___ New Directions & Controversies in Treatment of Cancer of the Breast & Prostate
*___ New Techniques in Genetics for Prenatal Diagnosis
___ Optimal Management of the Thyroid Patient
___ Sexual Myths and Perversions
___ Update in Immunology/Allergy
___ What's New in Dermatology

THURSDAY MORNING, NOV. 13
(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

___ Basic Cardiac Life Support
___ Common Pediatric Surgical Problems
*___ Cosmetic Surgery
___ Gait-Way to Successful Diagnosis
___ Infectious Diseases in the Elderly and Immunocompromised Patient (Alpha-Omega Part 3)
___ Non-Articular Rheumatism
___ Nutrition and Exercise
___ Role of Nutrients in Blood Pressure Control
___ The Silent Danger: Recognizing and Managing Closed Head Injury

THURSDAY AFTERNOON, NOV. 13
(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

*___ Advances in Plastic & Reconstructive Surgery — 1986
___ AIDS Update
___ Bioethics: From Here to Eternity (Part 3)
___ Carcinoma of the Breast
___ Common Anorectal Problems
___ Essentials of Acid Base and Fluid and Electrolyte Disorders
___ Food Poisonings, Carbon Monoxide Intoxication and Anaphylaxis
*___ Peripheral Vascular Diseases
___ Quality Control for the Office Laboratory

The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation, designates this activity meets the criteria for a maximum of 18 credit hours in Category I toward the requirements for Michigan relicensure and of the Physician Recognition Award of the AMA, provided it is completed as designed.

Please check the courses you wish to attend. In each case, *please indicate a second choice* should the first choice already be filled. Maximum attendance figures have been set for each course, depending on room size.

Send this entire page with your check. Confirmation of your reservation will be sent to you. Your course credentials, badge, and luncheon tickets must be picked up at the MSMS Registration Desk in the Great Lakes Exhibit Center.

Physicians must make their own hotel reservations prior to 10/17/86 direct with the Hyatt Regency Dearborn, Fairlane Town Center, Dearborn, MI 48126, 313/593-1234. In order to take advantage of the special conference rates, please mention that you will be attending the MSMS Annual Scientific Meeting.

See room reservation card for details about how you can win a complimentary room and dinner for two at Giulio's by making your room reservations early!

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Tuition Schedule for Courses:

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A deli sandwich lunch will be provided at no extra charge for paid registrants. Advance notice is requested so MSMS can give an accurate guarantee. Please indicate which days you want a lunch ticket.

- Tuesday lunch ☐ Wednesday lunch ☐ Thursday lunch ☐

- Indicate total number of half-day courses:

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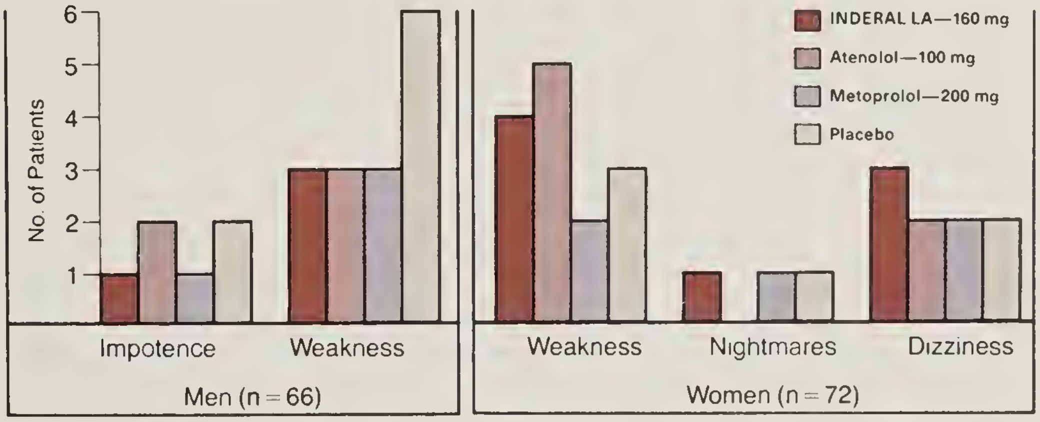

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ONCE-DAILY LONG ACTING CAPSULES 80 mg 120 mg 160 mg *

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(PROPRANOLOL HCl)

ONCE-DAILY LONG ACTING CAPSULES 80/50 120/50 160/50 *

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INDERAL LA and INDERIDE LA Capsules should not be considered simple mg-for-mg substitutes for INDERAL and INDERIDE Tablets Please see package circulars.

CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL® LA): Propranolol is contraindicated in. 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs

WARNINGS

Propranolol hydrochloride (INDERAL® LA): CARDIAC FAILURE· Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or propranolol should be discontinued (gradually, if possible)

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction following *abrupt* discontinuance of propranolol therapy Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hyperthyroidism Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm Propranolol does not distort thyroid function tests

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS INDERAL should be administered with caution, since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes In these patients, it may be more difficult to adjust the dosage of insulin Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease In patients with renal disease, thiazides may precipitate azotemia In patients with impaired renal function, cumulative effects of the drug may develop

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma

Thiazides may add to or potentiate the action of other antihypertensive drugs Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported

PRECAUTIONS

Propranolol hydrochloride (INDERAL® LA): GENERAL Propranolol should be used with caution in patients with impaired hepatic or renal function Propranolol is not indicated for the treatment of hypertensive emergencies

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test Withdrawal may lead to a return of increased intraocular pressure

CLINICAL LABORATORY TESTS Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS· Patients receiving catecholamine-depleting drugs, such as reserpine, should be closely observed if propranolol is administered The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY· Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential In 18 month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug

PREGNANCY Pregnancy Category C Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women Propranolo should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

NURSING MOTHERS. Propranolol is excreted in human milk Caution should be exercised when propranolol is administered to a nursing mother

PEDIATRIC USE: Safety and effectiveness in children have not been established.

Hydrochlorothiazide: GENERAL: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals

All patients receiving thiazide therapy should be observed for clinical signs of fluid o electrolyte imbalance, namely· Hyponatremia, hypochloremic alkalosis, and hypokalemia Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids Medication such as digitalis may also influence serum electrolytes Warning signs irrespective of cause are· Dryness o mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH

Interference with adequate oral electrolyte intake will also contribute to hypokalemia Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability) Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver or renal disease) Dilutional hyponatremia may occur in edematous patients in hot weather, appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening In actual salt depletion, appropriate replacement is the therapy of choice

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy

Insulin requirements in diabetic patients may be increased, decreased, or unchanged Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS Thiazide drugs may increase the responsiveness to tubocurarine

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient Thiazides may decrease arterial responsiveness to norepinephrine This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use

PREGNANCY Pregnancy Category C Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS· Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing

PEDIATRIC USE· Safety and effectiveness in children have not been established

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL® LA): Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy

Cardiovascular Bradycardia, congestive heart failure, intensification of AV block, hypotension; paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type

Central Nervous System. Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss; emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics

Gastrointestinal. Nausea vomiting, epigastric distress, abdominal cramping, diarrhea constipation; mesenteric arterial thrombosis, ischemic colitis

Allergic Pharyngitis and agranulocytosis; erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory Bronchospasm.

Hematologic· Agranulocytosis; nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune. In extremely rare instances, systemic lupus erythematosus has been reported

Miscellaneous Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol

Hydrochlorothiazide:

Gastrointestinal. Anorexia; gastric irritation, nausea, vomiting, cramping, diarrhea, constipation; jaundice (intrahepatic cholestatic jaundice), pancreatitis; sialadenitis

Central Nervous System Dizziness, vertigo; paresthesias, headache; xanthopsia

Hematologic: Leukopenia, agranulocytosis, thrombocytopenia; aplastic anemia

Cardiovascular Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics)

Hypersensitivity Purpura, photosensitivity, rash; urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis), fever, respiratory distress, including pneumonitis; anaphylactic reactions

Other· Hyperglycemia, glycosuria, hyperuricemia, muscle spasm; weakness; restlessness, transient blurred vision

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

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REFERENCE:

1. Ravid M, Lang R, Jutrin I The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily *Arch Intern Med* 1985,145 1321–1323

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Serving the medical profession since 1963

By William N. Hubbard, Jr., M

Trends in medicine projected

Hubbard

This article is taken from Doctor Hubbard's address at a recent fundraiser for the new University of Michigan Medical Center. Doctor Hubbard served on the Committee on Resources for the project.

I shall allude briefly to six general trends in medicine with which we are all familiar and comment briefly on their foreseeable futures. Finally, I shall offer you my own vision of the direction that a synthesis of these trends must take. The trends themselves will be alluded to in the form of dichotomies or polarized statements which are really forms of rhetoric that may be useful for advocacy but are dangerous as logical analytic devices. These trends are: 1) The tension between the Samaritan and the scientific role of the physician; 2) The tension between the personal health services and public health; 3) The tension between quality as perceived by the professional and the public conceptions of accessibility and accountability of outcome; 4) The tension between the intimate relationship of the patient and the professional on the one hand, and the movement toward competition and contracts for care on the other; 5) The tensions between the values that are imputed to the provision of health care through so-called non-profit corporate entities on the one hand, and for-profit corporate entities on the other; and 6) The tension between the health care system, and finally a synthesis.

The Samaritan role of the physician is a term introduced by the late Walsh McDermott to epitomize the caring responsibility of the profession. "The most common criticism made at present by older practitioners is that young graduates have been taught a great deal about the mechanism of disease, but very little about the practice of medicine — or, to put it more bluntly, they are too "scientific" and do not know how to take care of patients.

The last statement is a quotation from Francis Weld Peabody in an address to students at the Harvard Medical School in 1927. Similar views were expressed by Claude Dernard 50 years before Peabody. It was heard throughout the physician community in the 40s and 50s as the one year internship was replaced by the Halstead residency. It was heard in nursing as the hospital based certificate program was replaced by the collegiate baccalaureate program as the standard preparation for the registered nurse. It was been written about by Lew Thomas as he lampooned halfway medicine It has been acknowledged by students of malpractice as one of the underlying problems in that tortured area.

I have two observations to make. First, the problem is not new; second, the problem is not going to go away. It is the scientific that gives effectiveness that was undreamed of in Peabody's day to the humane concerns that justify the profession in the first instance. Scientific competence is a necessary but insufficient component of the definition of the modern physician. There is no trade-off available between the Samaritan and the scientific roles. For the future I would suggest that the tension will continue to be disruptive within the profession, while a proper balance of these two components represents the brightest and indeed the only hope for the profession's future.

Doctor Alan Gregg who was heavily responsible for the health-oriented activities of the Rockefeller Foundation during th

Continued on page 47

Among his many achievements, Doctor Hubbard is former dean of the University of Michigan Medical School, former director of the U-M Medical Center and has been a top Upjohn executive for 20 years.

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30s, 40s and 50s, coined the term "great medicine." He distinguished the necessary concern and involvement of the physician in both the personal health service and the public health aspects of medicine from the intimate professional responsibility in which personal health care is quite different in values and commitments from public health services.

Successes in public health are measured in population statistics having to do with life expectancy, cause of death, and incidence and prevalence of disease. The classical tool of public health is epidemiology. Public health concerns itself with the conditions which make feasible a personal health care system that is effective. Adequate nutrition, pure water, environmental hygiene with safe disposal of wastes, along with education, are some of the continuing concerns of public health. The prevention of specific disease and the systems that make health care accessible to those who can benefit from it link personal health services with public health practice.

Personal health care is an individual human undertaking. It is the result of an implicit contract between one person who has need of relief or assurance and another who claims special knowledge and skill in these realms. It is the faith of the patient that the professional will act exclusively on behalf of the patient's own interest and that the knowledge and skills are effective that constitute the vastly most powerful therapeutic agent in the armamentarium of the professional. The Hippocratic admonition to do good for the patient is as simple as it sounds and yet as complex as the philosophical issues raised by the ideas of should and good. We do not have outcome measurements for personal health services that satisfy the requirements of statistical reliability and validity.

The lack of objectively verifiable and quantifiable endpoints for personal health services has led many publications to assert that they have no value and the entire improvement of observed health is due to public health practices. This dilemma is urgent at the moment and will become absolutely critical as the economic pressures driving the nature of the health care system demand more and more proof of the utility of services provided by funds expended. So-called quality of life outcome measures are demonstrably deficient when compared with objectively verifiable endpoints. For the future both the biostatisticians and the clinicians will have to give up the self-indulgent joys of reiterating the difficulty and provide some resolution to the problem. In the absence of this research and intellectual effort, the biostatistical validation of intervention which started out as the brightest promise for bringing rationality to that realm, could prove to be itself fatally toxic.

Maternal and child health care may be theoretically available, but it is not readily accessible.

Lack of accessibility

The responsibility of the health care professional for assuring the quality of intervention services is now in sharp contrast with the lack of accessibility to these services and the condition of the services particularly for those who have no insurance and partly for those who have limited insurance. The tokens of accountability through DRGs and PROs are obviously and heavily motivated by the intention of reducing costs. The accountability of the profession for quality of outcome is in contest with the accountability for minimizing expenditures. At the present time the major professional response appears, in my own opinion, to be directed at the intrusion on professional decision prerogatives imposed by the arbitrary definitions of the review agencies. Coupled with this is the reasonable but increasingly preemptive concern with reimbursement levels and mechanisms. In my view, what is lacking is adequate accountability for the outcome of lack of accessibility to health services. Maternal and child health care may be theoretically available but it is not readily accessible.

The ideal of continuing comprehensive health services that are concerned with prevention and maintenance as well as the management of disease and illness is surely not accessible to that part of our population that falls outside of the present insurance programs. Although some effort has been made — particularly in California — to document the accountable costs of this lack of accessibility, it is unfortunately most frequently stated in terms of the economic burdens on hospital budgets in managing the diseases of these patients.

The support of the fragile aged in their own homes and their management during the years when they are not able to care for themselves is the most rapidly growing problem of accessibility in our community. We know very little of preventive medicine applied through individual health services as it affects the population over 50. When most of us were in medical school it would have been a crude joke to suggest that preventive medicine practices for patients over 60 was a real obligation

Continued on page 48

Mutual Memo

3

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RE: **Increasing patient satisfaction; preventing claims**

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Write down instructions, orders and prescriptions you give over the phone — in the office and at home. Keep a notepad and pen close by for documenting calls. Your office personnel also should note their phone conversations with patients.

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of the physician. Given the demographic structure of our population over 65 today, it is clear that this is a serious problem of accessibility.

For the future it is my own judgment that specialized nurse practitioners, social workers and primary care physicians must form collaborative professional groups in order to care for the needs of those who currently do not have adequate access to our health care system and who for the future are unlikely to be served by the hospital component of our health care system. The very young and the very old as well as the poor will engage our productive attention for the future if we are to retain the traditional values of the profession of medicine.

Insurance programs

The percentage of patients who pay for their own health service from their own resources is continuing to decrease as private and governmentally sponsored insurance programs of one kind or another expand. Most private health insurance is not actuarially based but represents a brokerage service whereby a company contracts with an insurance company to have it pay the bills for services that meet the conditions of the contact. This same principle was originally adopted when government health insurance was initiated.

At the present time both the companies that pay for these services and the government agencies that pay for them are less and less willing to accept this historic pattern. Prepaid group hospital insurance and prepaid group comprehensive health care insurance are over 40 years old. What is different is the sudden burst of growth in these mechanisms in the last decade. For the future it is almost certain that that growth will continue. Contracts with physicians and other health professionals for defined services on either a capitation or a group basis will inevitably grow. Some of these professional groups may, coincidentally, be on the staffs of hospitals and a joint contract will be written with the hospital and its professional staff. Large groups of patients will be assembled by contractors and in return for an assured volume of patients at a predictable payment rate, the unit price of services will be negotiated downward.

. . . the qualitative relationship between the patient and the health care professional will be at highest risk . . .

Because hospital beds are now in excess of need and there is certainly no apparent shortage of professionals, there will be competition based on cost. Whether there will be adequate contract provisions and adequate competition to provide quality has yet to be seen. Most particularly the qualitative relationship between the patient and the health care professional will be at highest risk in this evolving pattern.

During the 15 years I spent at Bellevue Hospital I became quite accustomed to having patients respond when asked to name their physician — *Bellevue Hospital*. For the future the question is an open one as to whether the quality that is related to the intimacy of the patient and professional in health services can be institutionalized. I have no clear vision of the future in this regar but a good deal of anxiety.

It is my own judgment that major corporations are more sensitive to and supportive of the traditional values of the professions than is the case with government. The issues o accessibility and quality that I have referred to previously are ones that major corporations also appreciate and are sensitive to. It is my opinion that the medical profession and the other health professions will find their greatest source of support in their efforts to maintain quality within the large corporations in the United States.

This is by no means to denigrate the small business. The simple fact of the matter, however, is that the very size and complexity of a large corporation requires it to be sensitive to the values of quality that underlie its own future. The corporate sector will indeed be, along with government, the largest purchaser of health services. They will go through insurance companies and HMOs owned by or contracted with insurance companies in negotiating the contracts for health services for which they will pay.

An analogous process will, I am sure, evolve in time with government. It is, however, the corporate sector that will understand the needs of the individual and the needs of maintaining the integrity of the professional. This kind of remake may sound counterintuitive since government has long maintained that it is the sole source of actions that are for the public benefit. The remorseless record of failure of the government in fulfilling its intentions in any operation it has undertaken from the Postal Service to the Defense Department is, I believe, beginning to suggest that there may be a problem in depending upon the government for the delivery of its intended services.

Business has always been a rovider for the health care ystem. Increasingly it will be a rovider of facilities. It has een and continues to be the ole source of diagnostic and erapeutic instruments. Its ole in the production of edicinals is such that it is the nique agency in our society hat is capable of bringing edicinals through the torurous approval processes to he point of general availabily. It will in the future be both he broker and the operator or contracts for health care ervices undertaken both by overnments and by private ompanies.

There is within that cororate sector an enormous egard for the best traditions f the medical profession and he health related professions. here is also a pained and ocasionally cynical acknowldgement of the failure of hat seems to be a surprisingy large portion of these rofessions to fulfill the values hat give them birth and social alidity. The corporate sector ill look to the best of the edical profession to maintain uality and respect for the inividual.

ources of funds

I am less sanguine about the orporate sector being a major ource of funds for research in he biomedical sciences. That a elationship will exist is beond doubt. It has existed for ver 40 years in a very formal ay. I would remind you that hloramphenicol was discovred in a laboratory at Yale niversity working on a conract with Parke Davis. That ontract was written because f the quality of the individual nvestigator. In my opinion hat principle remains. lthough groups representing nterdisciplinary research eforts may provide a basis for ore stable funding contracts n the future, I do not believe

Continued on page 482

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that the basic condition of contracting between a company and a gifted group or individual will alter. It is highly probable that the number of such arrangements will increase and this to the advantage of both the individual investigator and the company. I do not believe, however, that it is reasonable to expect the corporate sector to be a substitute for state and federal support of research — nor is it likely to replace individual philanthropy.

The final dichotomy that I would refer to is that of the so-called health care system and the so-called health business. The health care system is poorly defined but it is that series of efforts that are bound together by the human intentions that health should be improved. The health business responds to economically effective demand. This demand can be created by any number of systems including the Russian and Chinese forms of communism.

The health business in the United States derives from an open market economy in a democratic society. It does not have its own *genesis de novo* but is derived from the economic and social conditions of our society. Because it is based on an open and democratic concept of social organization, it finds itself in opposition to centralized, much less totalitarian forms of government. It is in this regard much closer to the value system of the independent professional than is usually recognized.

My synthesis for all of this goes back to Francis Weld Peabody 60 years ago. I quote the concluding sentence of that address.

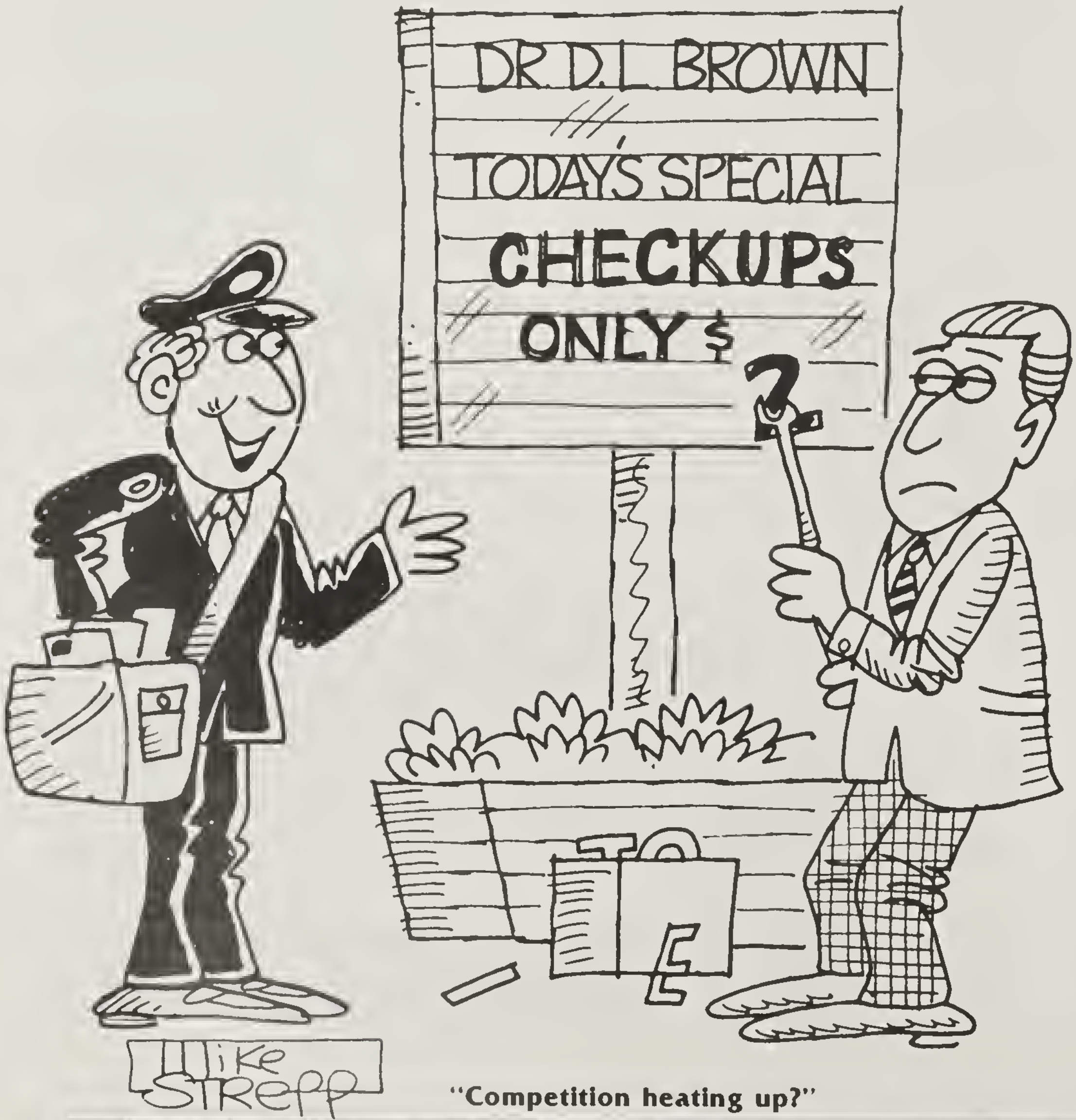
"One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient."

My vision is that the interprofessional rivalries and the hierarchical pattern of professional organization will be dissolved by a renewed commitment to serving the well-being of the individual patient. The maintenance of traditional professional values and the assurance of quality and accessibility of health services requires the firm and continuing collaboration of all of the health professionals.

It cannot and will not be done by physicians acting alone. Nurses, social workers, dentists, pharmacists and other health professionals can and should recognize that their long-term interests will be preserved only as the individual patient is served by their efforts. This common condition will become an available basis for a coalition of the professions. The professional best suited to provide a needed service at the time and in the place that is most effective and efficient will be the organizational pattern that will replace the awkward and ineffectual pattern that now exists.

My vision is that the professions should seek a reaffirmation of their role in the context of the benefits to the individual patient; that they should recognize that their strongest supporter rests in the corporate structure of the United States to the extent that the professions fulfill the values that are traditional to them.

Finally, our growth of scientific understanding will give feasibility for new and effective technology that, in combination with the professions and the corporations, can and should move us into the brightest of futures for great medicine and for the people who are served by it.☐



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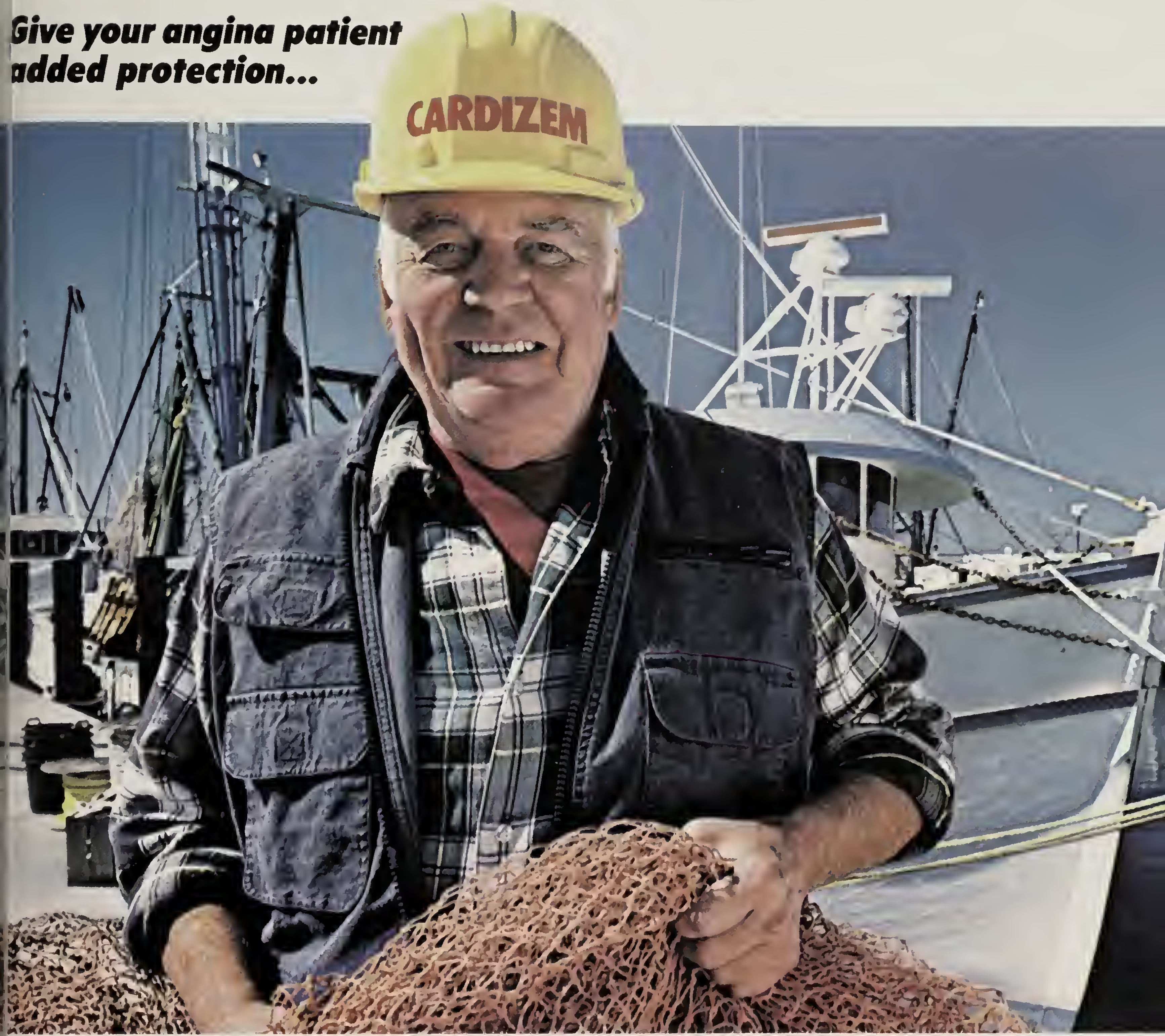

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CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0 48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem*
2. **Congestive Heart Failure.** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). An acute study of oral diltiazem in patients with impaired ventricular function (ejection fraction 24% ± 6%) showed improvement in indices of ventricular function without significant decrease in contractile function (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is limited. Caution should be exercised when using the drug in such patients.*
3. **Hypotension.** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension*
4. **Acute Hepatic Injury.** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS

General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are. edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%) In addition, the following events were reported infrequently (less than 1%).

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal.	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. *Issued 11/85*

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References: 1. *Frishman WH, Charlop S, Goldberger J, et al: Comparison of diltiazem and nifedipine for both angina pectoris and systemic hypertension. Am J Cardiol 1985;56:41H-46H.* **2.** *Weiner DA, McCabe CH, Cutler SS, et al. The efficacy and safety of high-dose verapamil and diltiazem in the long-term treatment of stable exertional angina. Clin Cardiol 1985;7:648-653.* **3.** *Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers: Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983;106(6).1341-1347.* **4.** *Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39.* **5**. *McCall D, Walsh RA, Frohlich ED, et al: Calcium entry blocking drugs: Mechanisms of action, experimental studies and clinical uses. Curr Probl Cardiol 1985;10(8):6-80.* **6.** *Chaffman M, Brogden RN: Diltiazem: A review of its pharmacological properties and therapeutic efficacy. Drugs 1985;29:387-454.* **7.** *Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982;50 (Sept):94-116.* **8.** *Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984;24(Dec):150-159.* **9.** *Johnston DL, Lesoway R, Humen DP, et al Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study Am J Cardiol 1985;55:680-687.*

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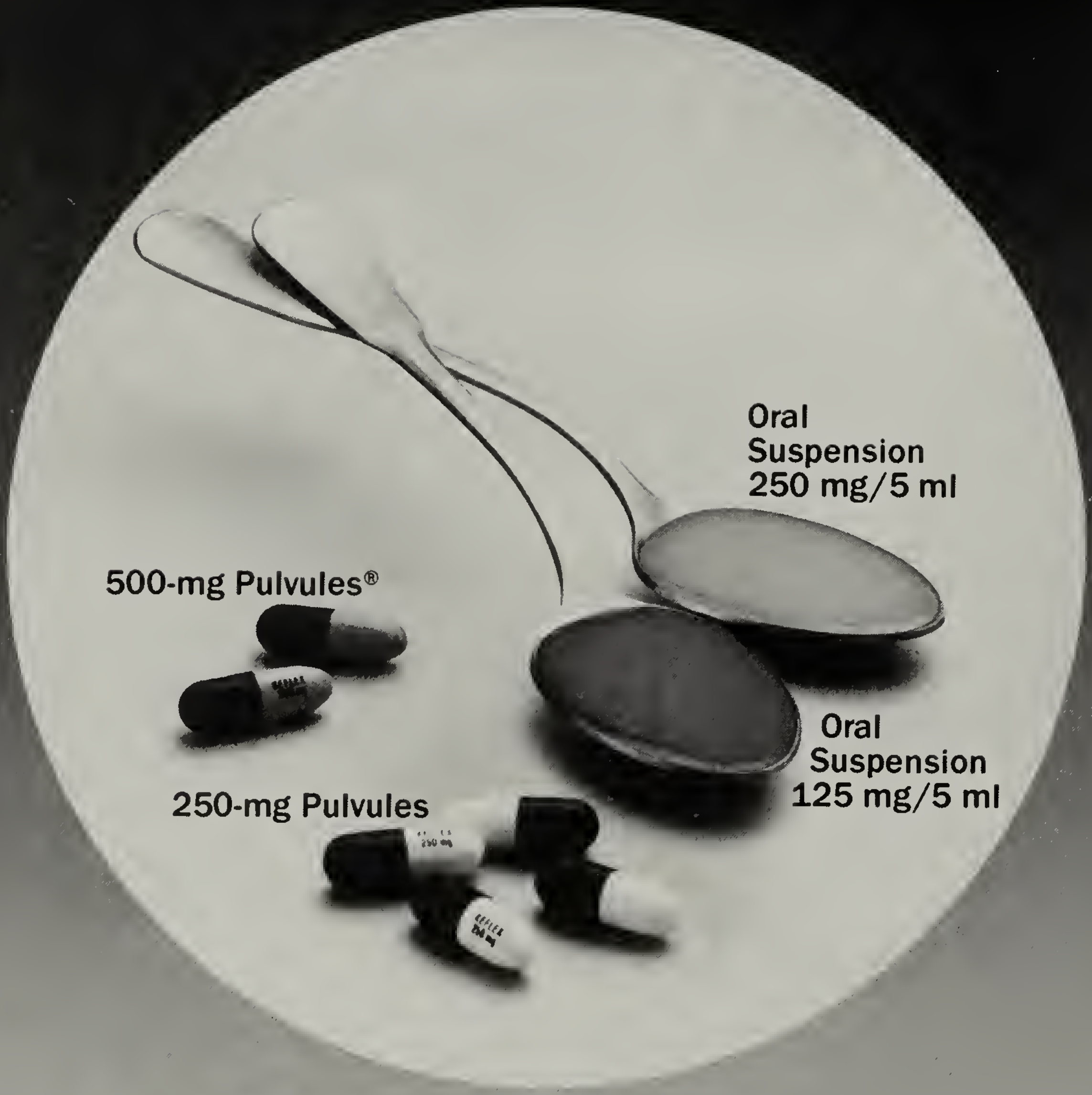
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Doctor Coury advises new and not-so-new physicians

W. Donald Weston, MD, left, dean of the MSU College of Human Medicine, chats with Doctor Coury after commencement exercises.

Excerpts of an address by John J. Coury, Jr., MD, AMA president, at the MSU College of Human Medicine Commencement, May 31, 1986:

“Congratulations to the CHM Class of 1986. Don't think you have reached the top of the mountain, you are only still on a plateau. I challenge you to keep seeking knowledge and climbing that mountain to best serve the health care needs of your patients.

“You have an awesome responsibility and obligation not only to yourself and to your family, but also to society.

“Be appreciative of the position you have within society. So often a physician is put on a high pinnacle; live up to the position in which society has placed you.

“While we appreciate your hard work, I ask you to also appreciate the sacrifices of your family, and of the taxpayers of this state who help support this public institution.

“Medicine is not a nine-to-five job. You must assure your patients of continuous care. Once you assume the care of a patient it is your responsibility to provide continuous quality care, no matter what the hour, no matter what the sacrifice of your personal time.

“You have inherited a great legacy of medicine—it is your responsibility to contribute well to this legacy.

“Remember, the patient is a human being and deserves to be treated always with respect, with dignity, and with compassion—no matter what walk of society he or she comes from—whether an indigent drifter or a wealthy community leader.

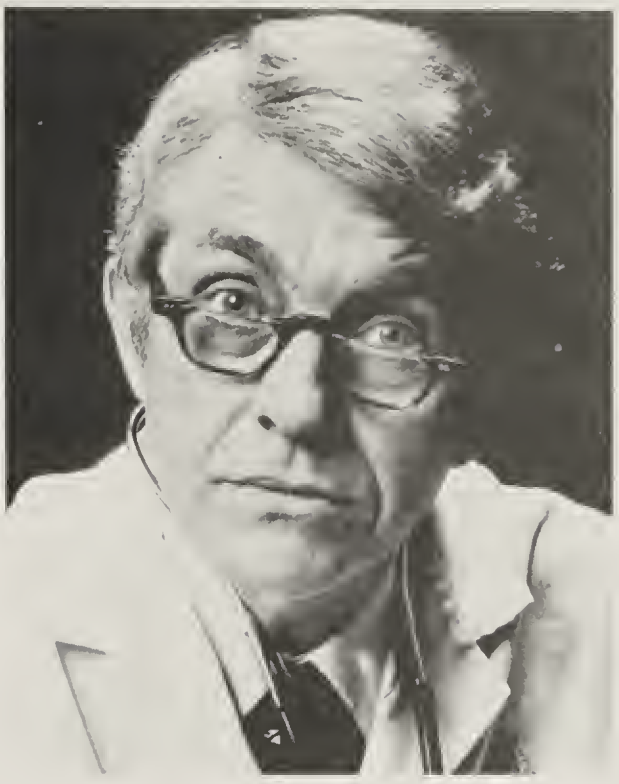
“You should be proud of your profession—but don't let that pride overtake you—don't let that pride become arrogance.

“Develop the respect of patients and peers—then you will enjoy the practice of medicine. Listen to your patients—LISTEN—you will do a better job in treatment of their needs and you will gain their respect.

“A physician must make a commitment to live by the highest moral principles in life—you must set goals and guidelines to live by and you must stay on course. Never compromise your patients' treatment for your personal gain or your personal plans—maintain that commitment.

“Remember, you are part of the community of life—both of the medical world and of the community and social structure where you live and practice. Get involved within that community—heal not only patients' problems, but help heal your community's problems as well.

“When you make this commitment to provide quality care you will find there is no greater reward as a physician than to have a family come to you saying, ‘Thank you, Doctor, thank you’.”☐



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By Richard D. Webe

Legal counsel discusses professional liability funds

The malpractice insurance crisis had led to many inquiries regarding alternatives to traditional malpractice insurance coverage. Premiums are staggering and the available limits still leave the physician's personal assets at risk. Private funding to protect against professional liability risks presents a possible alternative. Any analysis must include consideration of tax and insurance laws which impose potential impediments. New legislation in Michigan, however, presents a possible solution.

Under the Internal Revenue Code (IRC Section 162), insurance expenses are deductible only if a true insurance arrangement exists. A true insurance arrangement involves both the shifting and distribution of risk. This has been referred to as a transference of risk. If there is no transference of risk between separate entities or persons, payments into a fund are not tax deductible. The tax court has recently sustained the position of the IRS with respect to a malpractice insurance fund in *Anesthesia Service Medical Group, Inc.*, 85 TC No. 60.

This medical group consisted of approximately fifty anesthesiologists for which it provided insurance. As a result of escalating premiums, the medical group discontinued purchasing commercial insurance and provided protection through a trust. The medical group made contributions to the trust and a claims committee determined which claims were payable from the trust. The contributions were actuarially adequate to cover potential claims. The tax court denied the deductions taken by the medical group and held that the trust income was taxable. This involved tax deficiencies in excess of $900,000. The court found that there was no transference of risk for the reason that the source of payment originated with the medical group and the medical group retained excess exposure.

If there is a transference of risk among separate entities or persons, the Michigan Insurance Code is applicable. This would subject the fund to the capital, regulatory and other requirements of the Statute. A recent decision by Insurance Commissioner Herman W. Coleman supports this conclusion, although in that particular case it was decided that insurance licensure was not required. (*Mid-Michigan Health Care Systems, Inc.*, No. 86-8263-M). Mid-Michigan Health Care Systems, Inc. provided common coverage under a single private trust arrangement for three wholly-owned non-profit hospital corporations. The Commissioner's rationale was that all entities were consolidated for balance sheet purposes, commonly owned, and therefore constituted one integrated financial entity. Therefore, there was no transference of risk among separate entities and insurance licensure was not required.

A typical staff

A typical hospital staff of independent physicians would not fall within the rationale used by the Insurance Commissioner; it would not constitute one integrated financial entity. Privately practicing physicians or physician groups each represent a separate legal or financial entity for purposes of this analysis. Any payment by such physicians conducting their own separate practices into a single comingled professional liability fund would, therefore, constitute a transference of risk which is an essential element of insurance.

Recent legislation amending the Insurance Code might provide an appropriate vehicle to establish professional liability funds. Public Act 173, recently signed by the governor, provides for limited liability pools. The legislation is complex and presents a new alternative to traditional malpractice insurance coverage. Seven or more residents of Michigan may form a limited liability pool for the purpose of carrying on the

Continued on page 492

Mr. Weber is a partner with Kerr, Russell and Weber, MSMS legal counsel, Detroit.

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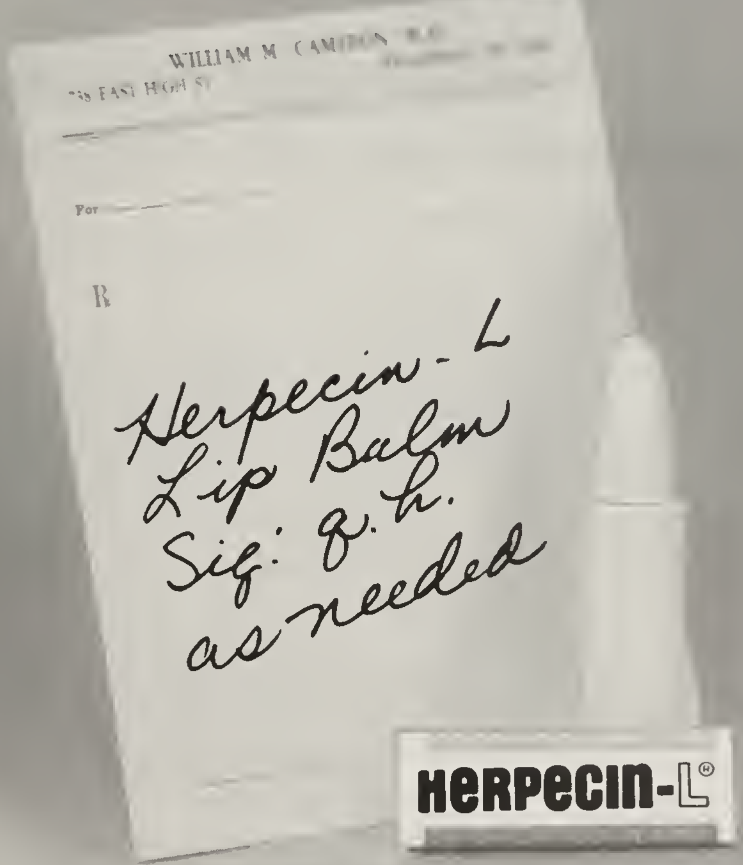

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assessment or cooperative plan of liability insurance. Professional liability is included. The threshhold for establishing such an entity is a finding by the Commissioner, after a public hearing, that liability insurance for the profession or class of professions is not readily available or is not available at a reasonable premium. The current medical malpractice insurance climate should clearly meet this threshold of eligibility, although the Insurance Commissioner has not yet issued interpretive guidelines or passed upon a specific case.

As a condition precedent to commencement of business, a limited liability pool must procure applications for insurance together with premiums from at least fifty eligible persons in the profession or class of professions which the pool undertakes to write. Monetary requirements are mandated by the legislation and actuarially sound reserves are required. Significantly, however, a limited liability pool is not subject to the requirements provided in Section 410 of the Insurance Code. These requirements, exempted by Act 173, mandate paid-in capital or unimpaired surplus in an amount not less than $1 million. The elimination of these capital requirements applicable to commercial insurers may be the most significant element of this new legislation. Members of the pool may be assessed their proportionate share to meet claims and expenses, and to maintain reserves, but in no event shall a member be liable for an assessment which is greater than his/her annual premium. The entity may secure funds for reserves and expenses by means of a loan, but interest rates and other limitations are specified.

Effective?

The effectiveness of Act 17 remains to be seen; but preliminary conclusions can be drawn. Without this legislation federal tax laws and state insurance laws present impediments to private professional liability funds. Limited liability pools created pursuant to Act 173 would substantially avoid these impediments. A transference o risk would occur, giving the physician a tax deduction for payment into the fund. Onerous capital requirements under the Insurance Code would be avoided. A limited liability pool may be the appropriate vehicle for a grou of physicians on a hospital staff to create and operate their own professional liability pool as an alternative to existing malpractice insurance.☐

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Board of Medicine Actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: Leroy Alcox, MD
Action, Date: Revoked, April 16, 1986
Reason: Violation of general duty, incompetency, and selling, prescribing, giving away or administering drugs for other than lawful diagnostic or therapeutic purposes.

Name: Donald F. Bosker, MD
Action, Date: Board of Medicine action taken April 26, 1986 — Stayed by Genesee County Circuit Court — May 22, 1986.

Name: Michael S. Quadir, MD
Action, Date: Summary Suspension Effective July 16, 1986
Reason: Continued licensure of doctor constitutes an imminent threat to the public health, safety and welfare requiring emergency action.

Name: Barry G. Siegel, MD
Action, Date: Revoked Effective August 1, 1986
Reason: Convicted of a crime related to and adversely affecting his ability to practice in a safe and competent manner; violation of general duty; incompetency; lack of good moral character.

Name: Richard W. Sundling, MD
Action, Date: Summary Suspension Effective July 16, 1986
Reason: Continued licensure of doctor constitutes an imminent threat to the public health, safety and welfare requiring emergency action.

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By Thomas J. DeKornfeld, MD

Board of Medicine faces these major issues

DeKornfeld

With this column Doctor DeKornfeld begins a regular *Michigan Medicine* feature on the Michigan Board of Medicine. Physicians are encouraged to send questions and comments about the Board c/o *Michigan Medicine*, PO Box 950, 120 W. Saginaw, East Lansing, Michigan 48823.

The Board of Medicine very much appreciates the opportunity to share some of its problems with the membership of MSMS. This column, made available to the Board by the courtesy of the MSMS Committee on Publications and the editors of *Michigan Medicine,* will present some of the issues before the Board, some of the problems which confront the Board and, hopefully, some of the solutions to those problems and concerns. In addition, the Board will be pleased to respond in this space to queries directed to it by the readers. In general the column will be written by the Board administrator, but from time to time one of the members of the Board will use this forum to air his/her views on some issue.

Board functions

In broad terms, the Board has two functions. These are: 1) to license, and 2) to regulate the physicians in the State of Michigan. Both are ongoing, continuous processes. The licensing process is largely a mechanical one. Applicants for licensure are screened to make sure that they meet all the requirements of the rules for the particular license (unlimited, clinical, academic limited, nonclinical limited, or educational limited) for which they apply. The Board office personnel checks the information and if it is complete and if there is no disciplinary action pending against the applicant in another state, the license will be issued. If the application is incomplete, the applicant will be advised and will be requested to supply the missing information.

The problem is relatively simple for graduates of US or Canadian medical schools. Any graduate from any of these schools is considered to have met the requirements for an MD degree. The problem is vastly different for graduates of a foreign (non-Canadian) medical school. While many of these schools are of the highest caliber professionally and ethically, some are marginal and some may be below acceptable standards. It must be apparent that this places the Board into an invidious position and this problem area will be the subject of my next column.

Regulation

On the regulatory side, the Board is charged with the responsibility of investigating allegations made against licensed physicians and to take disciplinary action against those physicians who have violated the Health Code. These allegations usually come from a person who believes that a physician has acted improperly or illegally. Under the recent amendments of the Health Code the Board must also investigate any physician who had a malpractice settlement or award in excess of $200,000, or three settlements or awards of any size within a ten-year period. Needless to say, this is a complex area which will be the subject of several future columns.

Yet another area of concern straddles the licensing and regulatory functions of the Board, namely the issue of continued competency and/or continuing medical education. This matter currently is under careful review by the Board and will also serve as the subject of one or more *Michigan Medicine* articles.

It should be obvious that the Board, its staff and the Bureau of Health Services have a number of major issues confronting them. We plan to share these with you and would be pleased to have your comments. ☐

Doctor DeKornfeld is administrator of the Michigan Board of Medicine.

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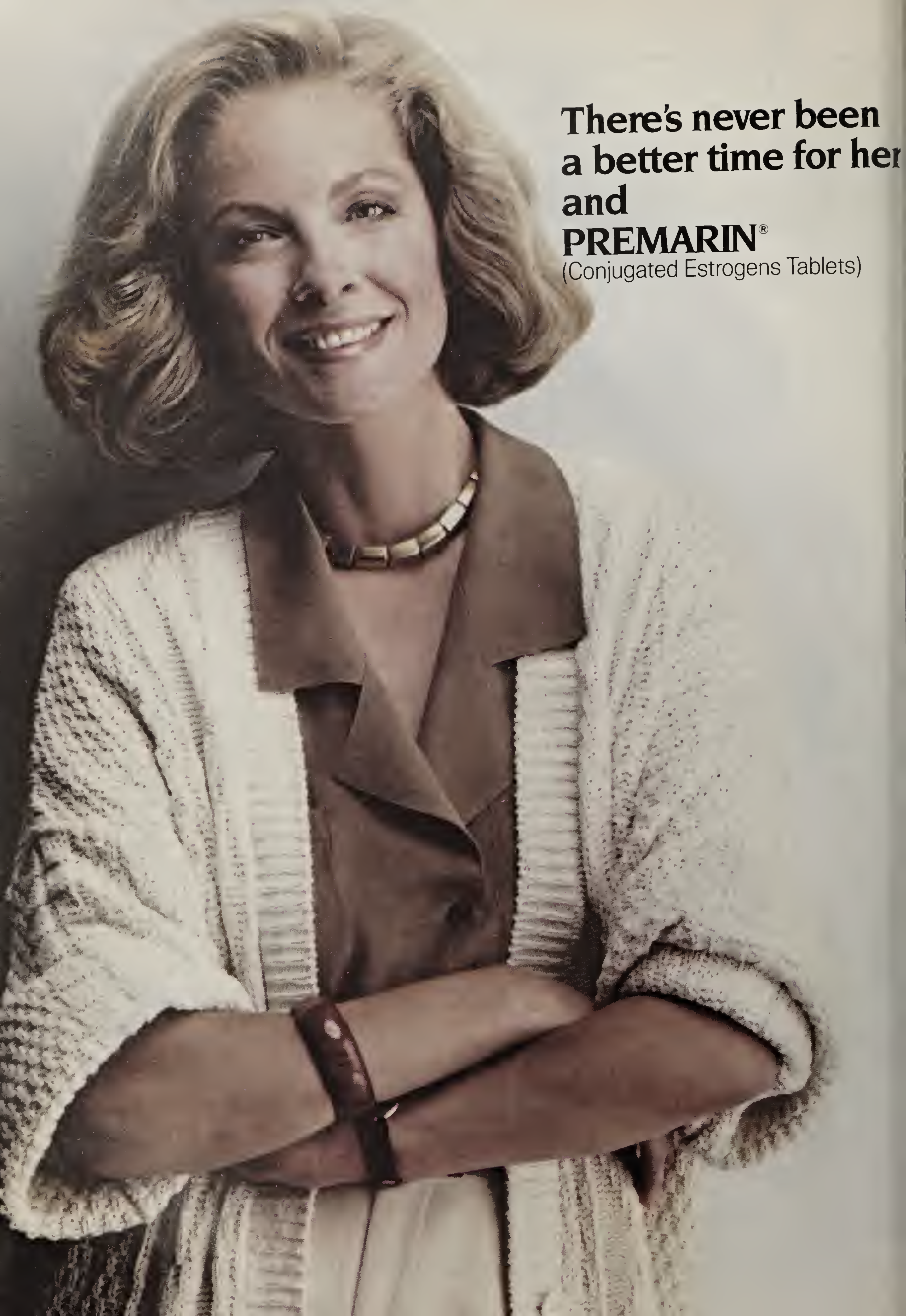
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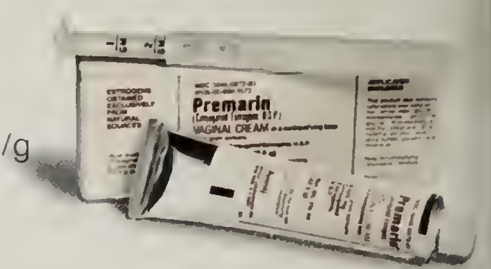

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1 ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year This risk was independent of the other known risk factors for endometrial cancer These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4 5 to 13 9 times greater than in nonusers The risk appears to depend on both duration of treatment and on estrogen dose In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration, it therefore appears prudent to utilize such a regimen Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses

2 ESTROGENS SHOULD NOT BE USED DURING PREGNANCY

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare This risk has been estimated as not greater than 4 per 1,000 exposures Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix Although these changes are histologically benign, it is not known whether they are precursors of malignancy Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects One case control study estimated a 4 7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000 In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters Tablets are available in 0 3 mg, 0 625 mg, 0 9 mg, 1 25 mg, and 2 5 mg strengths of conjugated estrogens Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) **Osteoporosis (abnormally low bone mass).** Atrophic vaginitis Kraurosis vulvae Female castration

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING)

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens (See PRECAUTIONS) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions 1 Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease 2 Known or suspected estrogen-dependent neoplasia 3 Known or suspected pregnancy (See Boxed Warning). 4 Undiagnosed abnormal genital bleeding 5 Active thrombophlebitis or thromboembolic disorders 6 A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy)

WARNINGS: Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans (See Boxed Warning) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement, it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease Large doses (5 mg conjugated estrog per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis When doses of this size used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderne abdominal mass, or hypovolemic shock Hepatocellular carcinoma has been reported in women taking estrog containing oral contraceptives Increased blood pressure may occur with use of estrogens in the menopause blood pressure should be monitored with estrogen use A worsening of glucose tolerance has been observe patients on estrogen-containing oral contraceptives For this reason, diabetic patients should be care observed Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastase

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic org and should include a Papanicolaou smear As a general rule, estrogen should not be prescribed for longer t one year without another physical examination being performed Conditions influenced by fluid retention suc asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation Certain patients develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleed mastodynia, etc Prolonged administration of unopposed estrogen therapy has been reported to increase the of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increa incidence of mental depression. Patients with a history of depression should be carefully observed Preexis uterine leiomyomata may increase in size during estrogen use The pathologist should be advised of estro therapy when relevant specimens are submitted If jaundice develops in any patient receiving estrogen, medication should be discontinued while the cause is investigated Estrogens should be used with care in pat with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia c young patients in whom bone growth is not complete If concomitant progestin therapy is used, potential r may include adverse effects on carbohydrate and lipid metabolism

The following changes may be expected with larger doses of estrogen:

a Increased sulfobromophthalein retention

b Increased prothrombin and factors VII, VIII, IX, and X, decreased antithrombin 3; increased epinephrine-induced platelet aggregability

c Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone measured by PBI, T4 by column, or T4 by radioimmunoassay Free T3 resin uptake is decreased, reflecting elevated TBG, free T4 concentration is unaltered

d Impaired glucose tolerance

e Decreased pregnanediol excretion

f Reduced response to metyrapone test

g Reduced serum folate concentration.

h Increased serum triglyceride and phospholipid concentration As a general principle, the administratio any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in hu milk

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contracept breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea, premenstrual-like syndro amenorrhea during and after treatment, increase in size of uterine fibromyomata, vaginal candidiasis, chang cervical erosion and in degree of cervical secretion, cystitis-like syndrome; tenderness, enlargement, secre (of breasts), nausea, vomiting, abdominal cramps, bloating, cholestatic jaundice, chloasma or melasma w may persist when drug is discontinued, erythema multiforme, erythema nodosum; hemorrhagic eruption; los scalp hair; hirsutism, steepening of corneal curvature, intolerance to contact lenses; headache, migra dizziness, mental depression, chorea, increase or decrease in weight; reduced carbohydrate tolerance; aggr tion of porphyria, edema, changes in libido

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1 *Given cyclically for short-term* use *only* For treatment of moderate to severe *vasomotor* symptoms, atro vaginitis, or kraurosis vulvae associated with the menopause (0 3 to 1 25 mg or more daily) The lowest dose will control symptoms should be chosen and medication should be discontinued as promptly as poss Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or t medication should be made at three- to six-month intervals

2 *Given cyclically* Female castration Osteoporosis Female castration—1 25 mg daily, cyclically Ac upward or downward according to response of the patient For maintenance, adjust dosage to lowest leve will provide effective control Osteoporosis —0 625 mg daily Administration should be cyclic (eg, three w on and one week off)

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate meas taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use *only* For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinue promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off)

Attempts to discontinue or taper medication should be made at three-to-six month intervals

Usual dosage range 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recur abnormal vaginal bleeding

References:

1. Whitehead MI, Townsend PT, Pryse-Davies J, et al Effects of estrogens and progestins on the biochemistry morphology of the postmenopausal endometrium *N Engl J Med* 1981,305 1599-1605 **2.** Paterson MEL, W Evans T, Sturdee DW, et al Endometrial disease after treatment with oestrogens and progestogens ir climacteric *Br Med J* 1980;280 822-824 **3.** Magos AL, Brincat M, Studd JWW, et al: Amenorrhea endometrial atrophy with continuous oral estrogen and progestogen therapy in postmenopausal women. *Ob Gynecol* 1985, 67 496-499 **4.** Whitehead MI, Lane G, Siddle N, et al Avoidance of endometrial hyperstimula in estrogen-treated postmenopausal women *Semin Reprod Endocrinol* 1983,1 1,41-52 **5.** Barnes RB, Ro Lobo RA Comparison of lipid and androgen levels after conjugated estrogen or depo-medroxyprogeste acetate treatment in postmenopausal women *Obstet Gynecol* 1985,66 216-219

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IMPACT

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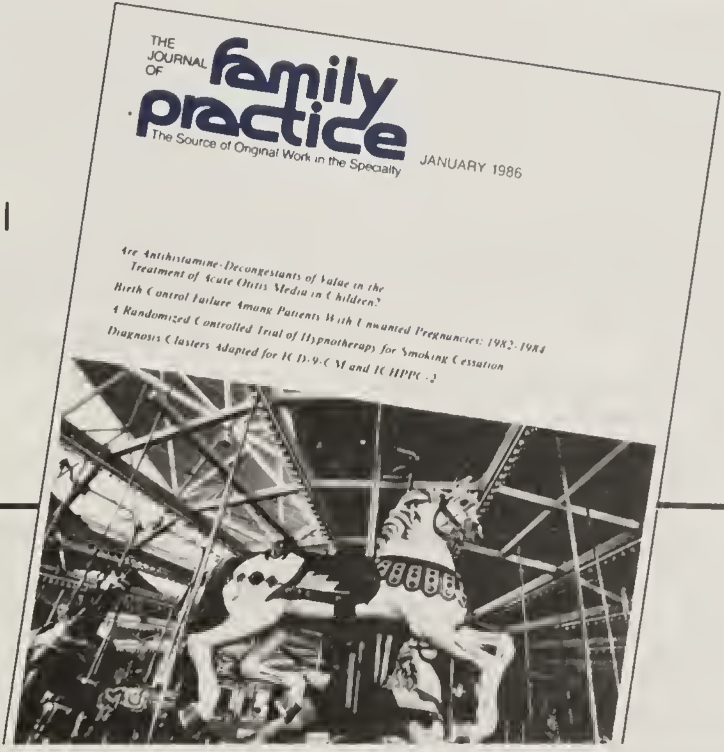

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Are Antihistamine-Decongestants of Value in the Treatment of Acute Otitis Media in Children?
Birth Control Failure Among Patients With Unwanted Pregnancies: 1982-1984
A Randomized Controlled Trial of Hypnotherapy for Smoking Cessation
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Reye's Syndrome update

There have been only two cases of Reye's Syndrome reported in Michigan since October 1, 1985. The Department of Public Health still requests prompt notification of any suspect case. Although it will not enroll any more children in the case-control study, it would like to maintain surveillance over the occurrence of this syndrome in Michigan.

Author seeks pre-1928 medical films

For a book to be entitled *Bringing Medicine to the Masses*, a University of Michigan associate professor of history is trying to locate any surviving medical or health-related motion pictures produced prior to 1928. He is particularly interested in finding films made for lay audiences, on such topics as hygiene, nutrition, TB, VD, child care, eugenics, etc. He also would appreciate hearing from anyone who remembers seeing such films in school, in the Army or in theaters before 1928, and from anyone who knows of specific references to such films in published or unpublished literature and documents from the pre-1928 period. Contact: Martin S. Pernick, Department of History, The University of Michigan, Ann Arbor 48109.

Precision diabetes control

Would more frequent insulin injections and closer control help diabetic patients retard their susceptibility to heart disease, blindness, kidney disease and other problems?

Henry Ford Hospital is seeking insulin-dependent diabetics to volunteer for a major international study designed to determine whether complications of diabetes can be prevented or delayed by precise control.

The Diabetes Control and Complications Trial, organized by the National Institutes of Health, is designed to study whether very careful control of blood glucose can prevent, slow or reverse the complications of diabetes. To do this, standard treatment will be compared to intensive treatment — three of four shots daily or continuous treatment by an insulin pump, self-monitoring of blood glucose, an initial hospital stay upon diagnosis and monthly clinic visits.

According to Fred Whitehouse, MD, head of Henry Ford Hospital's Division of Metabolic Diseases and a recognized expert on diabetes, "To volunteer for the study, patients must be between 13 and 39 and have had insulin-dependent diabetes from one to 15 years. The volunteer must not have any severe complications of diabetes, such as eye or kidney disease, and must not take more than two injections a day or use an insulin pump."

Volunteers who enroll in the study will be assigned to either the standard or intensive treatment on a random basis. Over the course of the study, volunteers will undergo eye examinations to track the condition of the blood vessels that line the back of the eye.

To volunteer for the study or for further information call Davida Kruger, RN, at (313) 876-3906.

Reduced toxicity in new chemotherapy regimen

A researcher at Wayne State University has identified a chemotherapy regimen for testicular cancer with anti-tumor effectiveness equivalent to the standard treatment but with reduced incidence and severity of toxic side effects. In a randomized clinical trial involving 122 patients, a combination of chemotherapy agents — vinblastine, VP-16, and cisplatin, (VPV) was shown to produce significantly fewer toxicities while maintaining effectiveness than the "standard" combination of vinblastine, bleomycin, and cisplatin (PVB). Based on these results, Michael K. Samson, MD, professor of medicine, recommends the VPV combination as the new standard of treatment for advanced testicular cancer.

Over the past ten years, major gains have been made in the treatment of advanced testicular cancer due in part to success with platinum-based combination drug therapy followed by surgical removal of residual disease. Today, the relapse rate for patients treated in this manner is less than 10 percent; the vast majority of cases are in remission long enough to be considered cures. Current and future research efforts are therefore aimed at refining and improving these advances, particularl with respect to the serious, sometimes life threatening effects of drug toxicity, such as bone marrow depression, and gastrointestinal, pulmonary, and dermatological problems.

In 1981, the Southwest Oncology Group initiated this randomized trial to compare the standard chemotherapy combination with another combination showing promise of reduced toxicities. Following four cycles of chemotherapy, patients in the study with remaining tumor masses underwent surgery.

The drug combinations under comparison did not differ significantly with respect to antitumor activity. However, while 65 percent of patients receiving the standard PVB combination experienced severe bone marrow depression, only 48 percent of patients receiving the "new" VPV combination were similarly affected.☐

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MSMS, MSMS/A, AMA & MEDICAL ASSISTANTS

September 17-20 — AMA Conference, Impairment and the Resident, Bonaventure Hotel and Spa, Fort Lauderdale, Florida, contact: Mark Stuart, Public Information Officer, AMA, 535 North Dearborn Street, Chicago, Illinois (312)645-4443.

October 1-2 — AMA Fifth Annual Science Writers Conference, Johns Hopkins University, Baltimore, Maryland, contact: Martha Boyce, Associate Science News Editor, AMA, 535 North Dearborn, Chicago, Illinois 60610.

October 15 — MSMS Public Affairs/Leadership Conference, Clarion Hotel, Lansing, contact: Sherry Wellman (517)337-1351.

November 7-9 — Michigan Medical Assistants "Grand Affair," Amway Grand Plaza Hotel, Grand Rapids, contact: Caroline Rich, MSMS Headquarters, East Lansing (517)337-1351.

November 10 — MSMS Auxiliary Board Meeting, MSMS Headquarters, East Lansing, contact: Viola Heins (517) 337-1351.

November 19 — MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, contact: William Madigan (517)337-1351.

OTHER MEETINGS

September 24 — Michigan Association for Medical Education, University Club, East Lansing, contact: Viola Heins (517)337-1351.

September 26-28 — Michigan Chapter, American Academy o Pediatrics, Hilton Shanty Creek Bellaire, contact: P. Miles Tiernan, Executive Secretary, 32245 Hearthstone, Farmington Hills 48010 (313)553-3646.

October 10 —Michigan Psychoanalytic Institute Second Annual Benefit presents "The Black Monk," Hilberry Theater, Wayne State University, contact: Kathleen Kunkel, 16310 West 12 Mile Road, Southfield 48076 (313)559-5855.

October 16 — A Seminar in Pediatric Nutrition, Garden City Osteopathic Hospital Auditorium, Garden City, contact: Mitchell Nimmoor, Garden City Osteopathic Hospital, (313) 421-3300, ext. 277.

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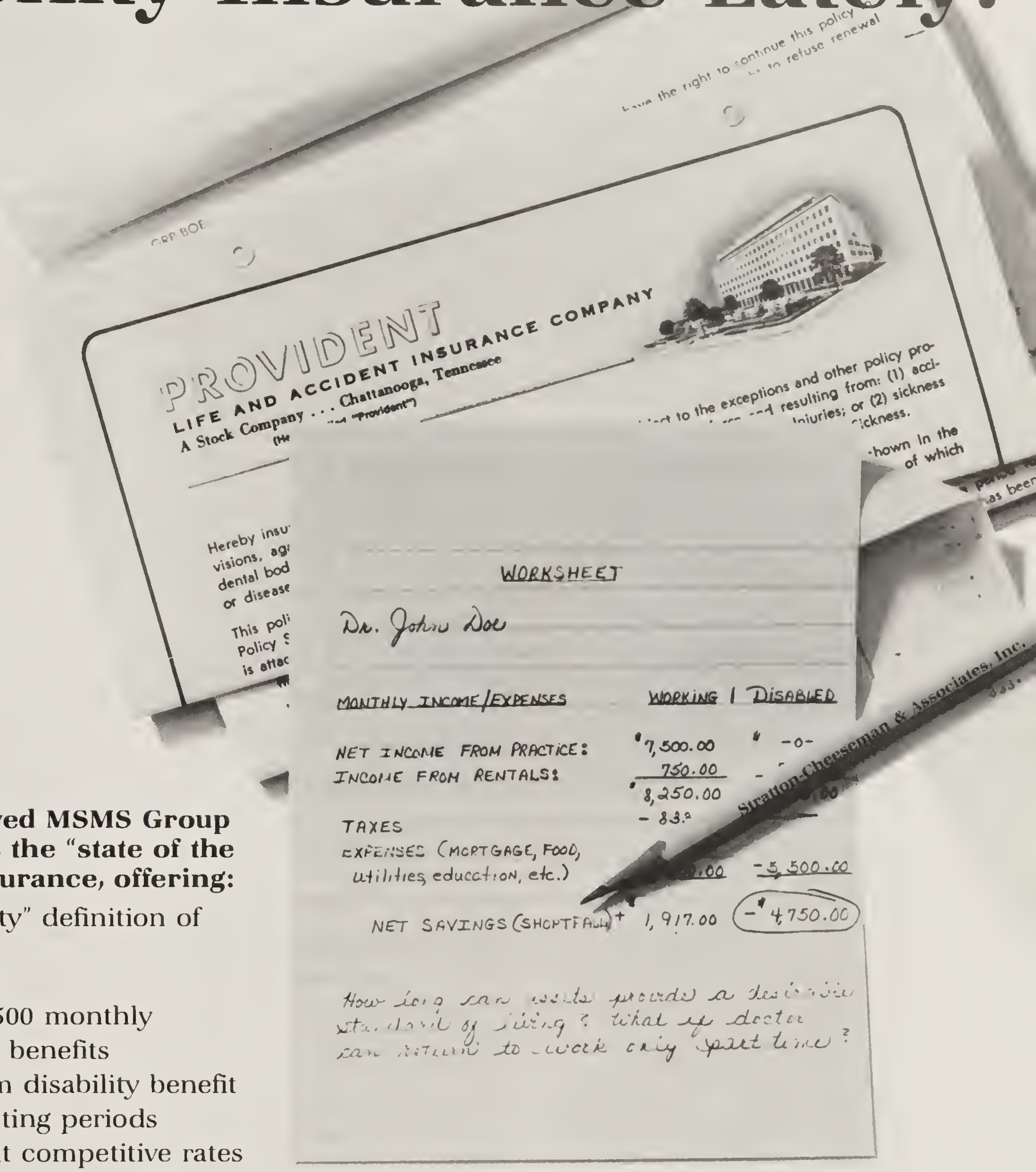

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PHYSICIANS IN THE NEWS

Richard J. McMurray, MD, MSMS immediate past president, was appointed to the AMA Council on Ethical and Judicial Affairs by John J. Coury, MD, AMA president and Port Huron general surgeon. Doctor McMurray, Flint OB/GYN, had been head of the Michigan Delegation to the AMA. **Frank B. Walker, MD,** Grosse Pointe Farms, is new head of MSMS' 15-member delegation. . . . **John Mucasey, MD,** Novi, was appointed to the Board of Directors of the American Academy of Medical Directors for a two-year term, ending in 1988. . . . **Kurt A. Haller, MD,** Dearborn, won the American Institute of Chemists Award for excellence in his studies at Wayne State University. . . . **Edward Pearce, MD,** Detroit, has been appointed to a three-year term on the Board of Trustees at St. Mary Hospital, Livonia. . . . **Lynn L. Swan, MD,** Menominee, has received a $1,500 award from the American Academy of Family Physicians to help finance her graduate training in family practice. . . . **Ronald A. Selbst, MD,** Bloomfield Hills, has been elected president of the Michigan Psychiatric Society. . . . **Morris Brown, MD,** Detroit, has been elected president of the Wayne State University School of Medicine Alumni Association. Doctor Brown is director of Critical Care Services at Sinai Hospital, Detroit. . . . **Raymond A. Gagliardi, MD,** Pontiac, has been elected president-elect of the American Roentgen Ray Society. The Society works to advance medical science through the study of radiology. . . . **Samuel M. Sefton, MD,** Kalamazoo, has been appointed Medical Director of Borgess Neonatology Services. . . . **George Grunberger, MD,** Detroit, has been awarded a $50,000 grant from the American Diabetes Association for his research on the effect of diet versus insulin on insulin receptors. . . . **Raymond E. Jackson, MD,** Southfield, has been elected to the Board of Directors of the Michigan Chapter of the American College of Emergency Physicians. . . . **Judith E. Tintinalli, MD,** Bingham Woods, has been re-elected to the Board of Directors of the American Board of Emergency Medicine. . . . **Ronald E. Trunsky, MD,** Detroit, has been chosen "Doctor of the Year" by the senior medical students at Wayne State University School of Medicine. . . . **Philip M. Margolis, MD,** Ann Arbor, has been elected to the Senate Advisory Committee for University Affairs, representing the University of Michigan. . . . **Charles Wright, MD,** Detroit, was appointed to the Michigan Sesquicentennial Commission by Governor Blanchard. Doctor Wright also is director of special grants for the Detroit Symphony Orchestra . . . **Harry Maisel, MD,** Bloomfield Hills, has received the Wayne State University Board of Governors Faculty Recognition Award for his book, "The Ocular Lens: Structure, Function and Pathology." Maisel is a professor of anatomy in the WSU School of Medicine. . . . **Ronald Krome, MD,** Royal Oak, who recently was named chief of emergency medicine at William Beaumont Hospital, served as the medical director for the Detroit Grand Prix. . . . **Sidney Baskin, MD,** Birmingham, was the recipient of a President's Cabinet Medallion at a University of Detroit banquet. Doctor Baskin is president of the National Kidney Foundation of Michigan and director of the Mount Carmel Mercy Hospital Kidney Center. . . . **Gilbert B. Bluhm, MD,** West Bloomfield, is the new president-elect of the Wayne County Medical Society. Doctor Bluhm is on staff at Henry Ford Hospital in Detroit. . . . **Richard P. Horsch, MD,** was installed as the new president of the Wayne County Medical Society. Doctor Horsch is on staff at St. Mary's Hospital in Livonia. . . . **Charles A. Murphy, DO,** Detroit, is the new president of the Michigan Association of Osteopathic Physicians. . . . **James H. Graves, MD,** Pontiac, has assumed the presidency of the Michigan Psychiatric Society for the 1986-87 term. . . . **Joseph Batdorf, MD,** Grand Blanc, recently served as a co director of the 1986 Buick Open Golf Championship. . . . **Mark Novitch, MD,** has been appointed senior vice president by the board of directors of the Upjohn Company. Doctor Novitch was formerly vice president and served as a senior administrator with the US Food and Drug Administration. . . . **Paul N. Suomi, MD,** Marquette, has been elected to a one year term as president of the American Lung Association of Michigan. . . . **Michael Kozonis, MD** Pontiac, has been elected an honorary life member of the board of trustees of the American Heart Association of Michigan. . . . **Jack Ryan, MD,** president, Detroit-Macomb Hospital Corporation, has been awarded the 1986 Meritorious Service Key Award by the Michigan Hospital Association for his outstanding contributions in the health care field. . . . **Joseph T. Batdorf, MD,** Grand Blanc, **Frederick W. Sherrin, MD,** Flint, and **James D. Walker, MD,** Grand Blanc, have been elected new officers of the St. Joseph Hospital Medical Staff. Doctor Batdorf will serve a two-year term as president, Doctor Sherrin will serve as vice president and Doctor Walker will serve as secretary-treasurer. . . . **Donald C. Smith** MD, Ann Arbor, will head the mental-health services program for the Peoples Community Hospital Authority. Doctor Smith was formerly director of the Michigan Department of Mental Health. . . . **Larry Robson, MD,** East Grand Rapids, has been named president of the American College of Surgeons, Michigan Chapter.

NEW MEMBERS

embers of the Michigan State Medical Society join in welcoming the llowing new members into a progressive state medical organization. SMS is dedicated to promoting the science and art of medicine, the otection of the public health, and the betterment of the medical ofession. Each new member is encouraged to join with other MSMS embers at both the local and state levels in achieving these goals.

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Continued on page 506

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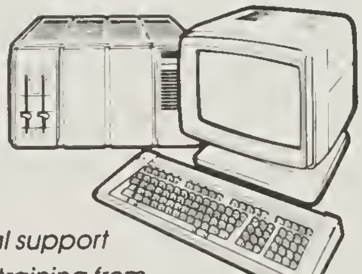

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Detroit 48201

Thomas A. Bruce, MD—CD/IM
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27600 Franklin Rd. #406
Southfield 48034

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Lincoln 48764

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501 Dunlap
Northville 48105

John R. Connors, MD—FP
863 Barrington
Grosse Pte. Park 48230

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200 Jefferson, SE
Grand Rapids 49503

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D2242 Med. Prof. Bldg.
U-M Hosp.
Ann Arbor 48109

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2047 Riverlawn Dr.
Kingwood 77339

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427 W. University Dr.
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Troy 48098

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Northern Michigan Hospitals
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Birmingham 48008

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Southfield 48075

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Ihsan Ul Haq, MD—IM
905 N. Macomb
Monroe

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Grand Rapids 49505

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3606 Camelot Dr., SE #2-B
Grand Rapids 49506

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Grand Rapids 49505

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Traverse City 49684

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1840 Wealthy St., SE
Grand Rapids 49506

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Petoskey 49770

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

Date: September 24, Recovery From Chemical Dependency. Location: Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital Continuing Medical Education Committee. **Contact:** Carol Mastroianni, Program Coordinator, CME, Saint John Hospital, 22101 Moross Road, Detroit, 48236 (313)343-3877. **Approved for:** 8 hours of Category I Credit.

Date: September 25-27, repeated November 13-15, Neonatal/Infant/Child Life Support. Location: Gilmore Health Education Center, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association and Southwestern Michigan Area Health Education Center. **Contact:** William H. Scott, MD, Southwestern Michigan Perinatal Association, 252 E. Lovell Street, Kalamazoo 49007 (313)383-6469. **Approved for:** 19 hours of Category I Credit.

Date: September 25-27, Diagnostic Ultrasound. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 15 hours of Category I Credit.

Date: September 26-28, American Academy of Pediatrics, Michigan Chapter 37th Annual Scientific Meeting. Location: Hilton Shanty Creek Summit Conference Center, Bellaire. **Sponsor:** Michigan Chapter, American Academy of Pediatrics. **Contact:** Mr. P. Miles Tiernan, 32245 Hearthstone, Farmington Hills 48018. **Approved for:** 7 hours of Category I Credit.

Date: September 26-28, Tutorial on Level I Myofascial Release Technique. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 24 hours of Category I Credit.

Date: September 27, Diabetes Mellitus: Tight Control — Does It Make A Difference? Location: Michigan Osteopathic Medical Center, 2700 Martin Luther King Jr. Blvd., Detroit. **Sponsor:** Michigan Osteopathic Medical Center.**Contact:** Ms. Sheila Smith, Coordinator, CME & Special Programs, Michigan Osteopathic Medical Center, 2700 Martin Luther King Jr. Blvd., Detroit 48208 (313)361-8020. **Approved for:** 5 hours of Category I Credit.

Date: September 27-28, Current Challenges and Physician Responses — Cardiology, Oncology, and Adolescent Medicine. Location: Burns Clinic Medical Center. **Sponsor:** Burns Clinic Foundation and Burns Clinic Medical Center. **Contact:** Kay Kelly, CME Coordinator, Burns Clinic, 560 W. Mitchell, Petoskey 49770. **Approved for:** 12 hours of Category I Credit.

Date: September 29-30, Caring for the Recreational and Elite Runner in the Office Practice. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Gayle Fox, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 13.25 hours of Category I Credit.

Date: September 29-October 1, Hemodynamic Monitoring and Management Seminar. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 14 hours of Category I Credit.

Date: October 1-3, Mechanical Ventilatory Support and Management. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313) 763-1400. **Approved for:** 15 hours of Category I Credit.

Date: October 2-3, Diabetes Care. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 16 hours of Category I Credit.

Date: October 2-3, SIDS/Apnea — Medical Management of the Infant at Risk. Location: Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo. **Sponsor: SIDS/Apnea Research and Treatment Center; Ross Laboratories; Southwestern Michigan Area Health Education Center. Contact:** Michael N. Musci, Jr., DO, Bronson Methodist Hospital, SIDS/Apnea Research and Treatment Center, 252 E. Lovell Street, Kalamazoo 49007 (616)384-8484. **Approved for:** 5 hours of Category I Credit.

Date: October 3, 16th Annual Cardiology Symposium. Location: Kalamazoo Hilton Inn, Kalamazoo. **Sponsor:** Borgess Medical Center; Kalamazoo Chapter of the American Heart Association; Michigan Academy of Family Physicians. **Contact:** E. Enrique Leguizamon, MD, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001 (616)383-5930. **Approved for:** 6 hours of Category I Credit.

Date: October 3, Advances in Strok Management. Location: Chelsea Community Hospital. **Sponsor:** MSMS Committe on CME Programming and Chelsea Community Hospital. **contact:** Debbie Buckmaster or Linda Visel (313)475-1311 ext 403. **Approved for:** 6 hours of Categor I Credit.

Date: October 4-5, National Conferenc for Chief Medical Residents. Location Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Bo 057, University of Michigan Medica School, Ann Arbor 48109-0010 (313 763-1400. **Approved for:** 10 hours o Category I Credit.

Date: October 7, Infections in the Diabetic Patient. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Kim Sadlocha, Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3073. **Approved for:** 6 hours of Category I Credit.

Date: October 9-10, Ear, Nose and Throat Practicum. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Jolene Glaspie, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 17.25 hours of Category I Credit, 17.0 hours of AAFP credit.

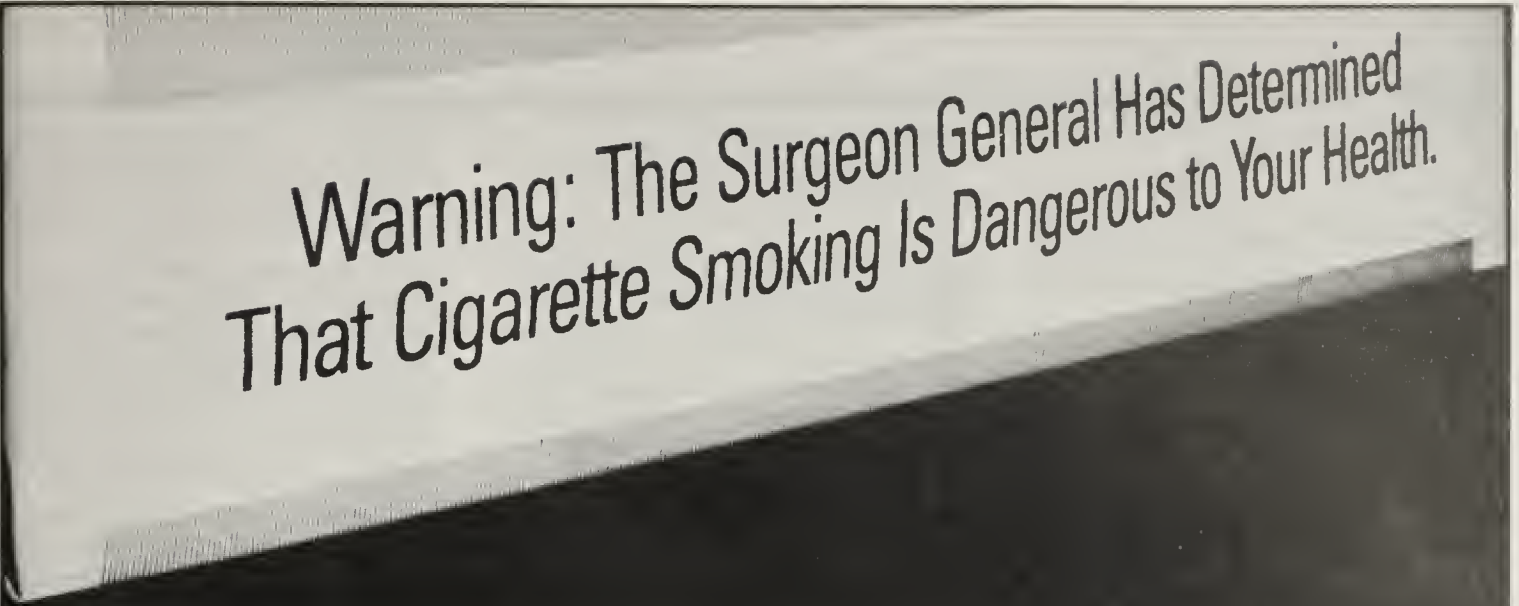
Date: October 9-10, Ins and Outs of Critical Care: Fluids, Nutrition and Renal Management. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010, (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: October 11-15, Tutorial on Level II Manual Medicine Techniques (Above Diaphragm). Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: October 16-17, Perinatology and Neonatology. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Janet Boomer, Towsley Center, Box 0201, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 13.25 hours of Category I Credit.

Date: October 16-18, Common Surgical Problems in Childhood. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 18 hours of Category I Credit.

Continued on page 510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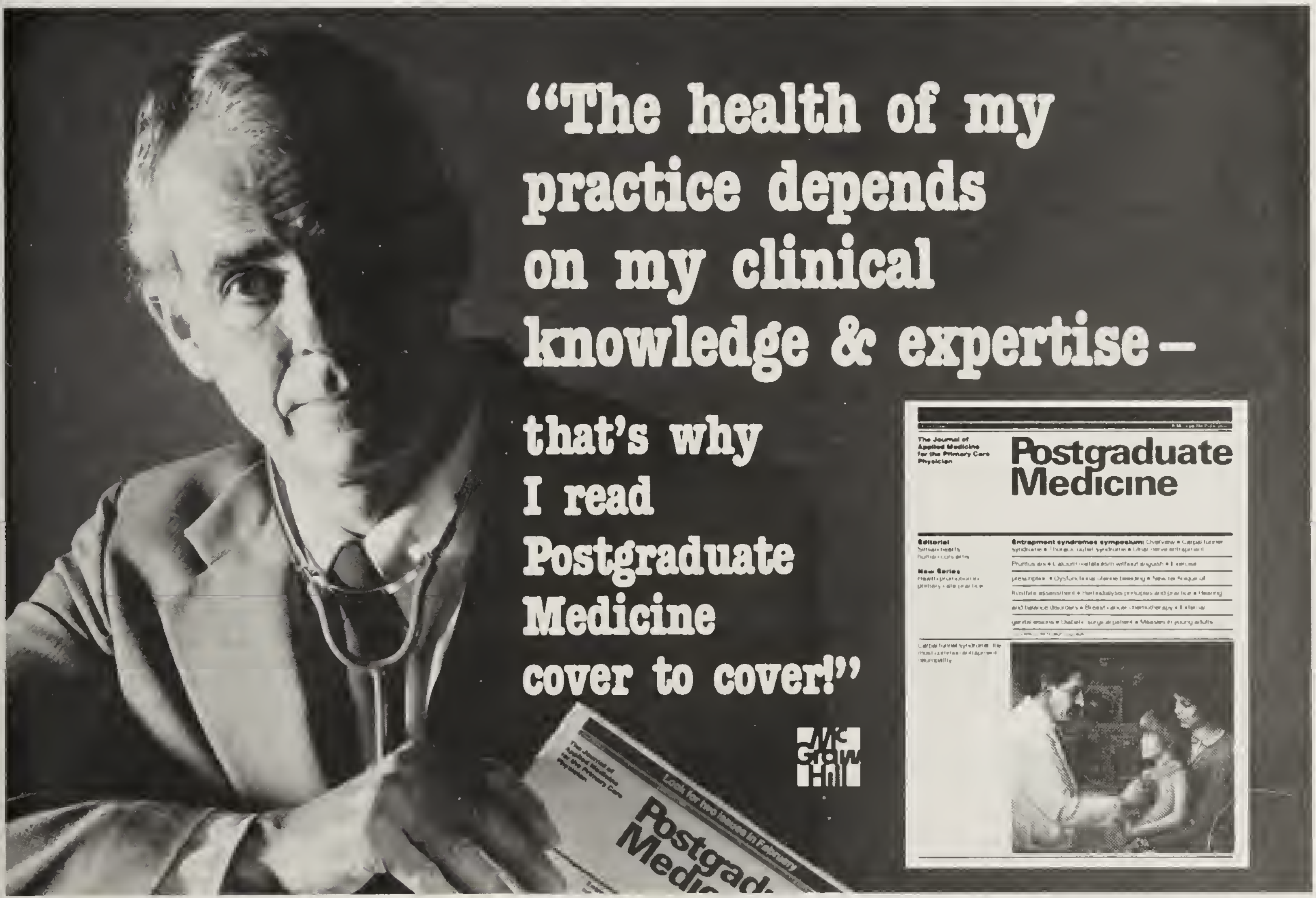
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CATEGORY I/Continued

Date: October 18 & 25, The Basics of Searching Medline. Location: Bronson Health Sciences Library, Kalamazoo. **Sponsor:** Bronson Health Sciences Library. **Contact:** Jeanne L. Hartenstein, Health Sciences Library, Bronson Methodist Hospital, 252 E. Lovell Street, Kalamazoo, MI 49007 (616)383-6318. **Approved for:** 8 hours (both days) of Category I Credit.

Date: October 18, Problems of Pain for the Practicing Physician. Location: Kresge Auditorium, Harper Hospital, Detroit. **Sponsor:** Gertrude Levin Pain Clinic. **Contact:** Elizabeth Holben, Gertrude Levin Pain Clinic, Harper Professional Office Building, 4160 John R., Suite 724, Detroit 48201 (313)745-9333. **Approved for:** 6 hours of Category I Credit.

Date: October 19-23, Tutorial on Level II Craniosacral Techniques. Location: Kellogg Center, MSU. **Sponsors:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: October 20-21, Care of the Elderly. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-0010. **Approved for:** 12 hours of Category I Credit.

Date: October 22, 3rd Annual Conference on Alcoholism. Location: Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Kalamazoo Alcohol & Drug Abuse Council; Southwestern Michigan Area Health Education Center; Gateway Villa; American Academy of Family Physicians. **Contact:** Charles L. Zeller, MD, 4th Floor Stryker Center, 1521 Gull Road, Kalamazoo, MI 49001 (616)388-7877. **Approved for: 6 hours of Category I Credit.**

Date: October 22, Rheumatology Day III. Location: Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital Continuing Medical Education Committee. **Contact:** Carol Mastroianni, Program Coordinator, CME, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313)343-3877. **Approved for:** 8 hours of Category I Credit.

Date: October 24-25, Advances in Multidisciplinary Approaches in the Treatment of Cancer of the Breast, Head and Neck, and Ovaries. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 10.5 hours of Category I Credit.

Date: October 24, Basic Cardiac Life Support Course for Physicians. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Bo 057, U-M Medical School, Ann Arb 48109-0010 (313)763-1400. **Approve for:** 6 hours of Category I Credit.

Date: October 25, Advanced Cardiac Li Support Course Recertification. Locatio Towsley Center, Ann Arbor. **Sponsor:** Ur versity of Michigan Medical School. **Co tact:** Anne Karolak, Towsley Center Bo 057, U-M Medical School, Ann Arb 48109-0010 (313)763-1400. **Approve for:** 8 hours of Category I Credit.

Date: October 25, Coronary Artery Di ease: Reducing the Risk and Treating th Problem. Location: Livonia West Holida Inn, Livonia. **Sponsor:**American Heart A sociation. **Contact:** Marilyn J. Veltma American Heart Association, 16310 V 12 Mile Road, P.O. Box 160, Lathrup Vi lage, Michigan 48076 (313)557-950 **Approved for:** 6 hours of Category Credit.

Date: October 25, Reconstruction in Ps choanalysis and Psychotherapy — A R consideration. Location: Hyatt Regenc Hotel, Dearborn. **Sponsor:** Michigan Ps choanalytic Society. **Contact:** The Mich gan Psychoanalytic Society, 16310 We Twelve Mile Road, Suite 204, Southfiel 48076 (313) 557-8633. **Approved for:** hours of Category I Credit.

Date: October 25, Primary Care Med cine: A Continuing Series. Locatio Henry Ford Hospital, Detroit. **Sponso** Henry Ford Hospital. **Contact:** Kim Sac locha, Henry Ford Hospital, Continuin Medical Education, 2799 W. Grand Blvd Detroit 48202 (313)876-3073. **Approve for:** 6.5 hours of Category I Credit.

Date: October 27-29, Impairment Evalu ation and Disability Considerations: Med ical and Legal Perspectives. Location Towsley Center, Ann Arbor. **Sponsor:** Un versity of Michigan Medical School. **Con tact:** Anne Karolak, Towsley Center, Bo 057, U-M Medical School, Ann Arbo 48109-0010 (313)763-1400. **Approve for:** 17 hours of Category I Credit.

Date: October 30-November 2, Ches Radiology: Pioneers and New Frontiers Location: Towsley Center, Ann Arbo **Sponsor:** University of Michigan Medica School. **Contact:** Anne Karolak, Towsle Center, Box 057, U-M Medical School Ann Arbor 48109-0010 (313)763-1400 **Approved for:** 14 hours of Category Credit.

Date: November 3-5, 1986 Michiga Statewide Conference on Child Abus and Neglect. Location: Towsley Center Ann Arbor. **Sponsors:** University of Michigan Medical School; Michigan Committe for the Prevention of Child Abuse. **Con tact:** Gayle Fox, Towsley Center, Bo 0201, Ann Arbor, MI 48109-0201 (313 763-1400. **Approved for:** 12.67 hours o Category I Credit.

Date: November 5, Frontiers in Diabeti Therapy. Location: Gilmore Center fo Health Education, Bronson Methodist Hospital, Kalamazoo. **Sponsors:** Upjohn Company, Southwestern Michigan Area Healt Education Center. **Contact:** Charles Zeller

MD, Continuing Medical Education
ice, SMAHEC, Stryker Center, 4th Floor,
21 Gull Road, Kalamazoo, MI 49001.
proved for: 4 hours of Category I
dit.

**te: November 7, 1986, Advanced
rdiac Life Support. Location:** Mercy
spital, Muskegon. **Sponsor:** Mercy Hos-
al. **Contact:** Sue Franklin, Box 358,
00 E. Sherman Blvd., Muskegon, MI
443 (616) 725-2506. **Approved for:** 8
urs of Category I Credit.

**te: November 7, Basic Cardiac Life
port Course for Physicians. Location:**
wsley Center, Ann Arbor. **Sponsor:** Uni-
sity of Michigan Medical School. **Con-
t:** Anne Karolak, Towsley Center, Box
7, U-M Medical School, Ann Arbor
109-0010 (313)763-1400. **Approved
:** 6 hours of Category I Credit.

**te: November 7-9, Tutorial on Manual
dicine Techniques Applied to the Ex-
mities. Location:** Kellogg Center, MSU.
onsor: MSU College of Osteopathic
dicine and College of Human Medicine.
ntact: Sandy Kilbourn, Director of Con-
uing Medical Education, MSU, A306 E.
Hall, East Lansing 48824 (517)353-
14. **Approved for:** 24 hours of Cate-
ry I Credit.

**te: November 8, Complications of Cor-
costeriod Therapy. Location:** Henry
rd Hospital, Detroit. **Sponsor:** Henry
rd Hospital. **Contact:** Kim Sadlocha,
nry Ford Hospital, Continuing Medical
ucation, 2799 W. Grand Blvd., Detroit
202 (313)876-3073. **Approved for:** 6
urs of Category I Credit.

**te: November 8-9, Advanced Cardiac
e Support Provider Course. Location:**
wsley Center, Ann Arbor. **Sponsor:** Uni-
rsity of Michigan Medical School. **Con-
ct:** Anne Karolak, Towsley Center, Box
7, U-M Medical School, Ann Arbor
109-0010 (313)763-1400. **Approved
r:** 16 hours of Category I Credit.

**te: November 12, Reproductive Endo-
nology and Infertility. Location:** Saint
n Hospital, Detroit. **Sponsor:** Saint John
spital Continuing Medical Education
mmittee. **Contact:** Carol Mastroianni,
gram Coordinator, CME, Saint John
spital, 22101 Moross Road, Detroit
236 (313)343-3877. **Approved for:** 8
urs of Category I Credit.

**te: November 11-13, MSMS Annual
ientific Meeting. Location:** Hyatt Re-
ncy Dearborn. **Sponsor:** Michigan State
edical Society. **Contact:** Sherry Fent,
SMS Headquarters (517)337-1351. **Ap-
oved for:** 18 hours of Category I Credit.

**te: November 12-14, Real-Time Ultra-
und in Obstetrics and Gynecology. Lo-
tion:** Towsley Center, Ann Arbor. **Spon-
r:** University of Michigan Medical
hool. **Contact:** Anne Karolak, Towsley
nter, Box 057, U-M Medical School,
n Arbor 48109-0010 (313)763-1400.
pproved for: 21 hours of Category I
edit.

**ate: November 13-15, Neonatal/In-
nt/Child Life Support. Location:** Gil-
ore Health Education Center, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association and Southwestern Michigan Area Health Education Center. **Contact:** William H. Scott, MD, Southwestern Michigan Perinatal Association, 252 E. Lovell Street, Kalamazoo 49007 (313)383-6469. **Approved for:** 19 hours of Category I Credit.

Date: November 17-18, Laser Medicine and Surgery: The Aerodigestive Tract. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 17 hours of Category I Credit.

Date: November 19-21, Laser Medicine and Surgery: Specialty Applications. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 22.5 hours of Category I Credit.

Date: December 6, How to Manage Tachycardias and Bradycardias. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Kim Sadlocha, Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3073. **Approved for:** 6 hours of Category I Credit.

Date: December 15-19, Principles of Manual Medicine. Location: Kellogg Ceter, MSU. **Sponsor:** MSU College of Osteopathic Medicine, College of Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: March 18, 1987, Dermatology. Location: Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital Continuing Medical Education Committee. **Contact:** Carol Mastroianni, Program Coordinator, CME, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313)343-3877. **Approved for:** 8 hours of Category I Credit.

Date: March 25-26, 1987, Michigan Conference on Maternal and Perinatal Health. Location: Hyatt Regency, Dearborn. **Sponsor:** MSMS. **Contact:** Sherry Fent, 120 W. Saginaw, East Lansing 48823 (517)337-1351. **Approved for:** 13 hours of Category I Credit.

Date: April 3-5, 1987, Tutorial on Level I Myofascial Release Technique. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, MA, Director of Continuing Medical Education, MSU College of Osteopathic Medicine, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 24 hours of Category I Credit.

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By Thomas R. Berglund, M

Summer's over

Summer's over, the kids are back in school, leaves are starting to turn, football's in high gear, and *most* organizations are returning to business — but not MSMS, as it never stopped.

Your MSMS leadership, committees, and staff have been meeting throughout the summer preparing for many, many upcoming activities.

This issue of *Michigan Medicine* is devoted to the MSMS Annual Scientific Meeting. The committee and staff have been preparing for this excellent CME program since last year's meeting. You can come to the Hyatt in Dearborn, November 11-13, 1986 and earn CME credit while your spouse spends your savings at the nearby Fairlane shopping mall.

Mark down October 15 and prepare to come to the Clarion Hotel in Lansing for the MSMS Public Affairs/Leadership Conference. This annual event was not held last year because of the Rally, so the committee and staff have been working to make this a *GREAT* conference.

More efforts

As soon as the ink dried on Governor Blanchard's signature on the 15 tort reform bills he signed, our Task Force on Professional Liability met, prepared a work plan, and began working on Phase II. We did not get all that we wanted in Phase I and we have started working anew. We will need *your* help to prevail.

MSMS has been awarded a grant from the Department of Public Health to develop an AIDS educational program. Frederick Bryant, MD, chairman of the Scientific and Educational Reference Committee of the Board will chair this important project. The committee has been meeting and a hospital network teleconference has been scheduled for November 4.

Plans have been proceeding to develop and publish *Mediscene*, a magazine for the public. A pilot issue has been published and critiqued, and now you can subscribe to issues for your waiting room. (See page 487)

At the annual meeting of th AMA, besides installing John Coury, MD, as AMA President, electing Donald Crandall, MD, for a second term on the Council on Medical Service, and electing Immediate Past President Richard McMurrary, MD, to the Council on Ethical and Judicial Affairs, the House of Delegates established a Young Physicians Assembly. MSMS has responded with a Task Force to pick a delegate and alternate to that assembly and possibly form an MSMS Young Physicians Assembly.

MSMS has also been developing an extensive risk management program. This effort is chaired by Speaker of the House, Gerald Mandell, MD.

In addition, we supported the petition drive of the Committee of Concerned Citizens, have been working on a proposed joint venture with MPMLC, have continued to develop the Impaired Physicians Program, have contacted MPRO about member concerns established a Group Health Insurance Trust, and are beginning to develop some educational efforts about cocaine.

Yes, the summer is over and it's time to get active again, even though MSMS never gets a summer vacation!☐

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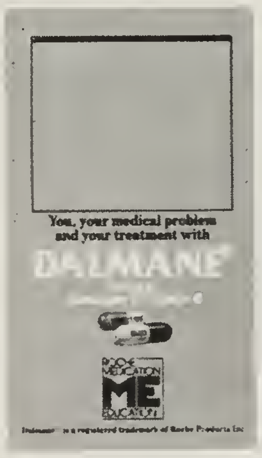
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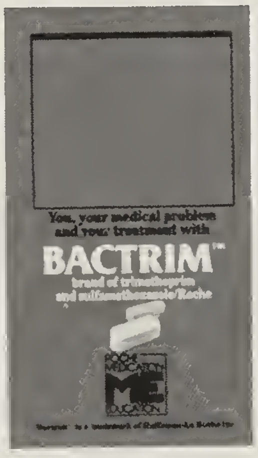
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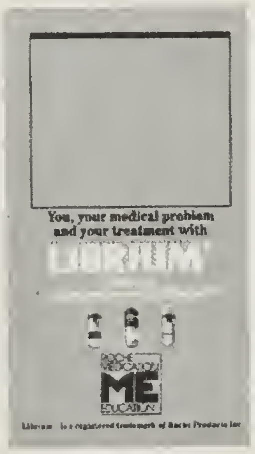
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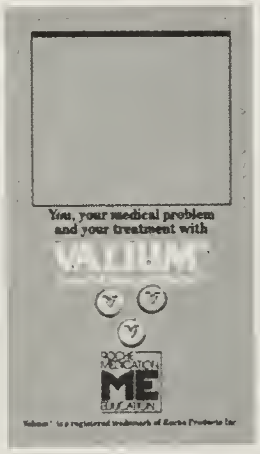
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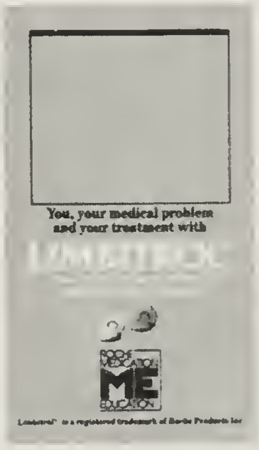
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MICHIGAN MEDICINE

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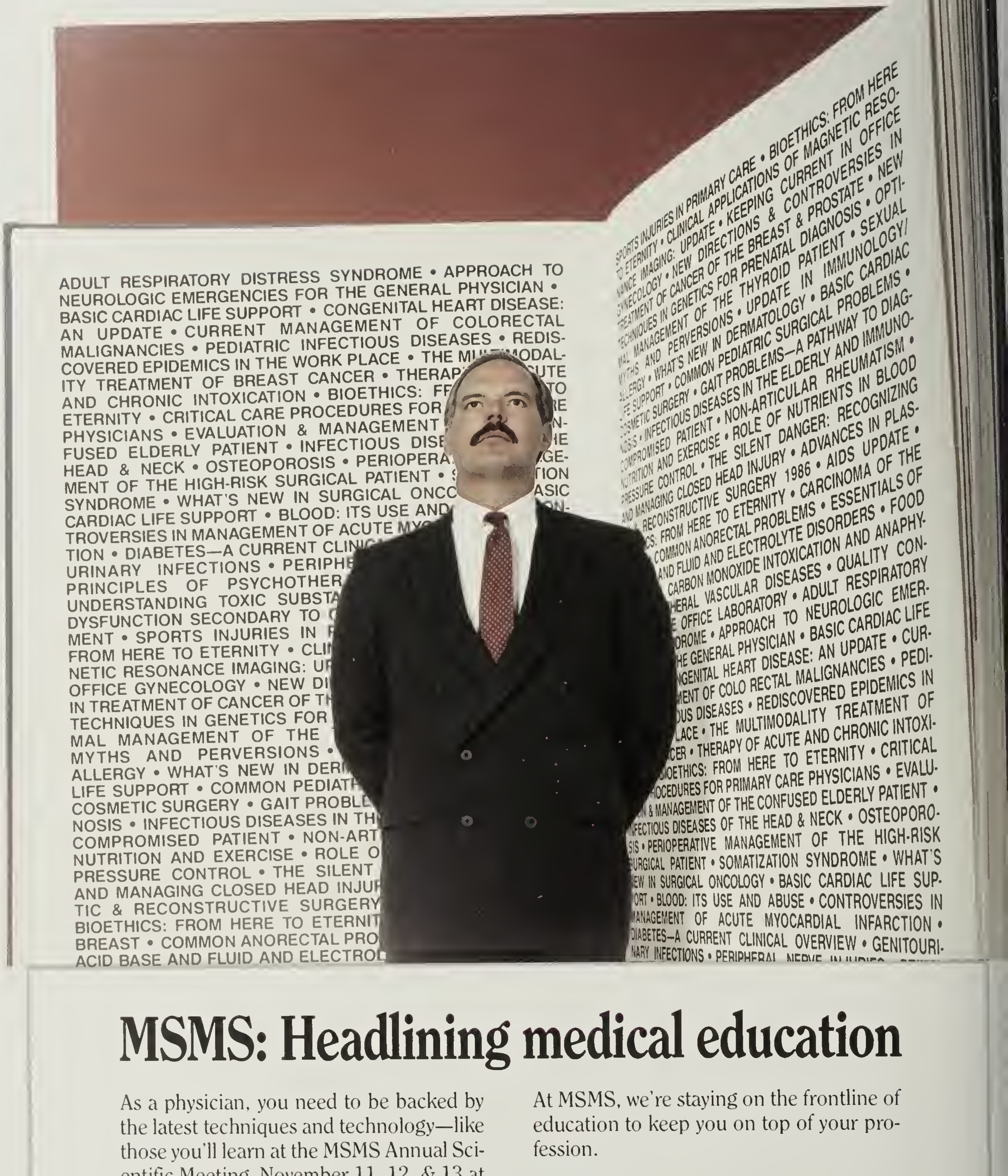
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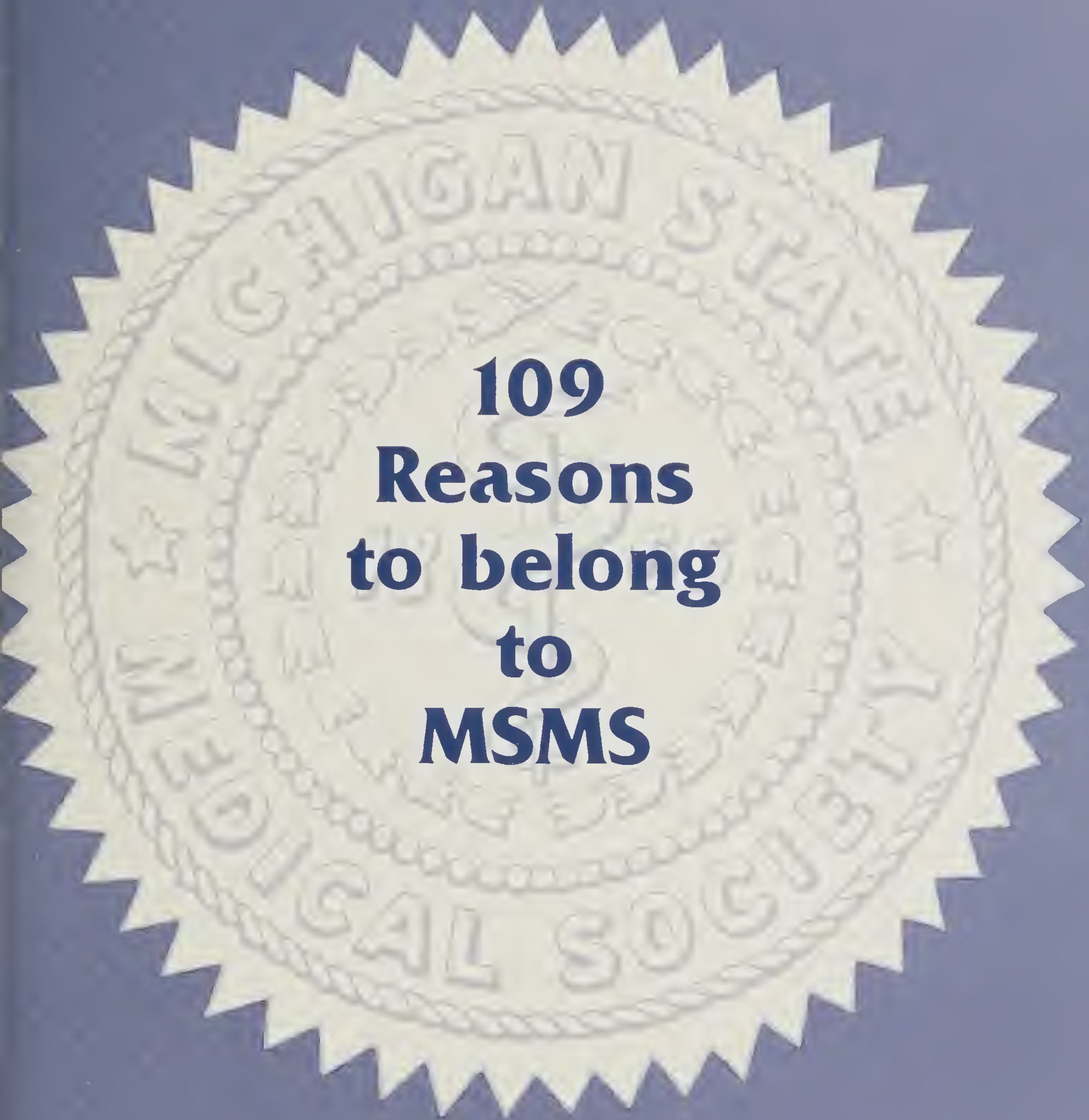
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109 Reasons to belong to MSMS

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Dear Colleague:

A fellow physician invites you to become a member of your medical society. What is your reply? What is your image of organized medicine? Do you see it as an "old boys' club," merely a social organization which meets a few times a year to reminisce about "the good old days"? Or had you heard about the march on Lansing, the Maternal Health Conference or the Annual Scientific Meeting or one of the other medical society activities? Are you intrigued and wanting to know more?

Well, the entire complexion of organized medicine, and more specifically the Michigan State Medical Society, is changing. While it has never been a static organization, many things are happening in the Society to better reflect the needs and ideas of the membership.

Who are we?

Who are our members? The Michigan State Medical Society has over 11,000 physician members, who comprise more than 85 percent of the practicing physicians in the state. They live and practice all over Michigan, from the smallest community in the Upper Peninsula to the most populous areas of Wayne County. All specialties are represented — from allergy to urology. Practice patterns vary from the solo family practitioner to the physician in the multi-physician group to the medical school deans. Spanning the entire length of the career of medicine, MSMS has over 500 medical students and more than 250 resident members, as well as 879 life and 824 retired members. Of the active and resident members, 4,822 are over 45 while 3,739 are under 45. MSMS has 2,611 foreign medical graduates and 890 women physicians. (And you thought this was an "old boys' club"?!!)

What are all these physicians doing? More than 230 physicians lend their services to provide quality educational programs for more than 1,500 other physicians at the Annual Scientific Meeting held each November. Special sections have been formed for hospital staff physicians, women physicians, foreign medical graduates, students, residents and young physicians, all determined to address the needs of these groups and to formulate plans to meet them. Other physicians meet regularly with legislators to advocate for physicians and their patients regarding pending health care legislation. Some physicians devote extensive time and energy to serve on the Board of Directors or as an elected official of the Society, helping to make the Society work for *all* its members. (While all of the activities and accomplishments cannot be numbered, look at the comprehensive list in this section.)

Tangible benefits

MSMS has many tangible benefits. A variety of health, life and disability insurance plans are available to MSMS members. The Michigan Physicians Mutual Liability Insurance Company was created through the efforts of MSMS to help provide liability insurance for its members. Other benefits include car lease/rental programs and travel opportunities. Physicians Service Group, Inc. is a member service MSMS subsidiary, providing accounting, membership and support services to many of the Michigan speciality societies. It also offers office management and medical marketing consultations to members, as well as a credit card program so that patients may charge their physician visits on VISA or MasterCard.

All these activities are part and parcel of MSMS. But in the final analysis, MSMS is physicians like you and me, coming together for the betterment of medicine, our patients and ourselves. In the pages that follow, several physicians share their impressions of MSMS. I invite you to read on and meet MSMS. Then, if you haven't alread please join us. Our strength is our members, our strength is *you!!!*

Cathy O. Blight, MD

Sincerely,
Cathy O. Blight, MD, Chairman
MSMS Committee on Membership Recruitment and Retention

ROFESSIONAL LIABILITY

• MSMS works for passage
a special appropriation in
e 1986 Medicaid budget for
professional liability initia-
ve, which is used for fee in-
eases for physicians' prenatal
d obstetrical services.

• MSMS hosts a tort reform
alition of lobbyists from
ue Cross Blue/Blue Shield,
chigan Hospital Association
e State Chamber of Com-
erce and various insurance
mpanies to coordinate legis-
tive efforts on the tort re-
rm package.

• MSMS produces the "Med-
al Malpractice Options in
ichigan" report which was
stributed to the legislature,
vernment officials and
unty medical and specialty
ciety presidents.

• MSMS continues to seek
bility reform in the area of
untersuit legislation, a
icter statute of limitations,
d a strict cap on non-
onomic damages.

• MSMS sponsors and coor-
nates a rally which brings
,000 people to Lansing to
otest the malpractice insur-
ce crisis in Michigan.

• MSMS undertakes research
risk management to lower
ofessional liability premiums.

• MSMS participates on the
vil Liability Justice Reform
alition which was coordi-
ted by the Michigan State
amber of Commerce.

LEGISLATION AND REGULATION

• MSMS works aggressively to support the current Public Health Code to limit unauthorized expansion efforts by a number of limited health care practitioners in their efforts to expand their scope of practice or in their efforts to become independent practitioners. MSMS provides input on state budget issues of concern to physicians and their patients.

• MSMS sponsors a number of Washington visitations for Michigan physicians with the Michigan Congressional Delegation. This includes both individual and group visitations in Washington DC.

• MSMS continues to work directly with AMPAC and MDPAC in an effort to increase physician action efforts across the state.

• MSMS continues to coordinate and co-host county medical society legislative breakfasts with local legislators.

• MSMS works aggressively in supporting legislative efforts to assure reguired request protocols for organ donations. HB 4965 was passed as a result of medical and health care lobbying efforts.

• MSMS continues to update members who are interested in legislative issues through the Government Relations Agenda (GRA Sheet).

• MSMS continues its aggressive legislative efforts in heading off non-physicians' efforts to expand their scope of practice such as laboratory testing, full skeletal x-rays and general physicals.

• MSMS supports SB 850 which calls for a ban on the sale of organs for profit.

• MSMS works in conjunction with the MSMS Auxiliary in hosting the Annual Auxiliary Legislative Day.

COMMUNITY HEALTH

• MSMS supports changes in Medicaid reimbursement for vaccines, leading to the development of a dose replacement program for OPV, MMR and DPT vaccine.

• MSMS successfully supports continued funding for the production of DPT vaccine by the Michigan Department of Public Health.

• MSMS supports passage of the Clean Indoor Air Act, which restricts smoking in public places.

• MSMS hosts the initial Ad Hoc Committee on Organ Transplantation in order to discuss the appropriate standards for organ transplantation in the state of Michigan.

• MSMS participates through the MSMS Committee on Child Abuse and Neglect in the fall Governor's Conference on Child Abuse.

• MSMS supports the Governor's Conference on Aging with both financial and physician participation.

- MSMS continues to assist the governor's Infant Mortality Special Task Force through the Michigan Department of Public Health, through physician representatives.

- MSMS, through physician participation, participates in the drug utililization review project with the Michigan Department of Social Services.

- MSMS testifies a number of times through MSMS physicians/leadership on EDTA chelation therapy.

- MSMS studies issues affecting mothers and their babies and recommends appropriate action to the MSMS Board of Directors.

- MSMS works with Michigan legislators to introduce legislation requiring warning labels on smokeless tobacco products.

MEDICAL EDUCATION

- MSMS establishes a relationship with the Michigan Council on Graduate Medical Education which collects and monitors data regarding GME programs in the state in order to evaluate the impact on medical care and make recommendations.

- MSMS publishes and distributes the Hospital Summer Externship Catalog, a resource for medical students.

MEDICAID/MEDICARE

- MSMS blocks passage of a sole source contract for Medicaid ambulatory laboratory services.

- MSMS continues to respond to the AMA Medicare freeze legislative alerts as a part of a national effort to lobby members of Congress on the Medicare freeze issue.

CONTRACT EVALUATION/NEGOTIATION

- MSMS sponsors seminars on joint venturing between hospitals and doctors and other business/medical related topics.

- MSMS assists individual physicians and medical staff leaders in developing equitable privileging processes.

- MSMS assists medical staffs in resolving disputes between physicians and hospital administrations.

RESEARCH & SOCIOECONOMICS

- MSMS continues its parti ipation in a work group hoste by the Michigan Department Public Health designed to assess the problems of physicia involvement in managing nurs ing home care.

- MSMS maintains over 50 committees and task forces t study the important issues affecting the medical professio and to instigate appropriate action.

- MSMS maintains a socioeconomic resource library an responds to member requests for data on various socioeconomic subjects.

- MSMS assists physicians resolving claims payment pro lems with health insurance ca riers.

- MSMS provides information and advice on alternativ reimbursement programs.

- MSMS participates in a working group to make recom mendations to the legislature regarding the state's health planning and certificate of need processes.

EALTH CARE FINANCING

• MSMS testifies before the
atewide Health Coordinating
ouncil on planning policies
r Certificate of Need
views.

• MSMS continues efforts to
arify and to strike the current
r case participation language
der Public Act 350 — The
ue Cross/Blue Shield reor-
nization act.

• MSMS works jointly with
terested health care organi-
tions in increasing the Cer-
icate of Need threshold to a
ore appropriate level.

• MSMS participates in
gislative discussions on man-
tory reimbursement for nurse
esthesiologists, nurse mid-
ves and nurse practitioners.

• MSMS maintains a net-
ork of contracts to resolve
oblems with third party
lling.

MARKETING & PROFESSIONAL SERVICES

- MSMS assists physicians, medical students, resident physicians, and spouses who suffer from substance abuse or emotional disorders.

- MSMS provides intervention services, assistance in obtaining treatment, monitoring, and support during the impaired physician's re-entry period.

- MSMS sponsors educational conferences on professional impairment.

- MSMS disseminates information to physicians, hospitals, the public and other interested individuals and organizations on impairment.

- MSMS presents an Annual Public Affairs Leadership Conference which offers physician leaders a chance to hear top speakers on issues shaping physicians' lives. Medical, social, economic and governmental developments are discussed.

- MSMS provides a highly competitive credit card program for patients to pay for services.

- MSMS provides educational seminars on practice management.

- MSMS provides educational seminars on personal finances.

- MSMS sponsors a collection service for physicians.

- MSMS provides information on computers and computerizing the medical office.

- MSMS provides a program of individual practice management counseling.

- MSMS provides individual programs for personal financial counseling.

- MSMS sponsors a personal credit card program designed for physicians.

- MSMS provides information on sources of capital and expertise for programs to expand and improve medical practices.

- MSMS continues to explore and negotiate for new services for the physician market.

- MSMS provides professional administration of specialty societies.

- MSMS provides information on medical equipment selection and financing.

- MSMS presents seminars and individual consultations on practice marketing.

- MSMS provides assistance to physicians who are establishing a practice.

- MSMS provides information on the availability of professional liability insurance.

- MSMS, in cooperation with the MSMS Physician Service Group, presents six seminars for residents on how to set up practice, five seminars for practicing physicians on medical management and marketing, and several for medical office staff.

- MSMS provides a discount magazine subscription service for physicians.

- MSMS administers MSMS' Insurance Programs: group term life, disability for physicians and their employees, special accident, business overhead protection and health insurance.

- MSMS increases non-dues income through special programs.

- MSMS continues to offer as member benefits the Hertz and Avis Rental Car Programs, lease car program, travel programs, subscriptions, and placement services through the Michigan Health Council.

MEDICAL STAFF ACTIVITY

- MSMS distributes a monograph on the legal status of the medical staff.

- MSMS provides a forum for medical staffs to present issues of concern to organized medicine through its Hospital Medical Staff Section.

- MSMS provides answers to legal questions for individual physicians and medical staff leaders.

CONTINUING MEDICAL EDUCATION

- MSMS, through an active programming committee, is accredited to present conferences for Category I Credit to physicians, as well as to many allied health professionals.

- MSMS presents an Annual Scientific Meeting which attracts over 1,200 physicians and offers more than fifty courses covering all medical specialties.

- MSMS presents an annual Conference on Maternal and Perinatal Health which is planned by and presented to physicians, nurses and others involved in the field. The conference draws nationally-prominent speakers and is attended by nearly 700 physicians and health professionals every year.

- MSMS, through its Committee on Sports Medicine, presents a conference for physicians, coachs and trainers that attracts 200-300 attendees every year and has fostered a relationship with the Michigan High School Athletic Association which has been instrumental in improved care for young athletes.

- MSMS has an active co-sponsorship program that helped other health organizations present 18 programs on a variety of medical topics to physicians all over the state.

- MSMS has ongoing relationships with Michigan's mec cal schools, medical specialty societies and other groups which have resulted in many cooperative educational efforts.

- MSMS continues to study ways to include innovative educational experiences, such as teleconferencing, compute assisted self study and "hand on" wet clinics in its overall educational efforts.

- MSMS is expanding on plans to become an active resource for providing inform tion about top quality speake in every specialty, when requested.

- MSMS accredits and mor tors 89 hospitals and organizations in Michigan which provide Category I CME programming for physicians.

- MSMS maintains a currer list of accredited organizations.

HEALTH EDUCATION

- MSMS, with the director' office, serves as staff for the Health Education Foundation which supports health education projects and provides loans on a selective basis to impaired physicians to aid in their recovery.

- MSMS is a member of th coalition of interests groups supporting Senate bills 4 and promoting the need for funding of health promotion in th state of Michigan.

- MSMS continues its seat-belt use education efforts wit the statewide Coalition on Safety Belt Use.

IENTIFIC

- MSMS receives state fund- g to coordinate a statewide fort to educate health ofessionals about AIDS.

- MSMS develops and dis- minates physician desk refer- ce cards on maternal and rinatal care.

- MSMS develops and pro- des Guidelines for Regional- ed Perinatal Care to regional nters, community hospitals, dividual physicians and other terested parties.

- MSMS serves as a re- urce to the Michigan Depart- ent of Public Health on issues rtaining to maternal and rinatal care.

- MSMS educates physicians recognize the symptoms of bstance abuse and trains em to develop intervention ills.

DARD OF MEDICINE

- MSMS works aggressively r funding for a full-time phy- cian Board of Medicine ad- inistrator.

- MSMS continues to make ccessful recomendations to e governor on physician ard of Medicine appoint- ents.

- MSMS hosts the Michigan ard of Medicine and con- nues ongoing contacts with members.

OMMUNICATIONS

- MSMS produces and dis- butes brochures for patients, cluding: Breast Cancer Treat- ents — A Helpful Guide for u; AIDS Update; Illness or In- y Away from Home; If meone in Your Family Wants Become a Doctor.

- MSMS publishes *Michigan Medicine*, a monthly, award-winning socioeconomic journal of news and features of interest to physicians.

- MSMS publishes *Medigram*, a weekly newsletter reporting up-to-the-minute developments in the rapidly changing environment in which physicians practice.

- MSMS has just launched *MediScene*, a lively and attractive quarterly magazine for the public. *MediScene* fosters a closer physician/patient relationship and clarifies the world of medical care from the physician's point of view.

- MSMS produces a special health/medical care supplement to Michigan newspapers which relays important and timely information to the public.

- MSMS sends out a variety of press releases and public service announcements, places physicians on radio and television programs and arranges interview opportunities for all news media.

- MSMS produces a Video Newsletter, a new tool for liaison with county medical society leaders and members. The Video Newsletters bring highlights of recent MSMS Board of Directors' meetings to members across Michigan.

- MSMS responds to numerous requests from the public on a wide range of subjects—from medical treatments to medical records.

- MSMS monitors media coverage of medical and public policy developments affecting physicians.

- MSMS is poised to publish LifeGuide, a first-aid supplement to telephone books in selected Michigan metropolitan areas.

PROFESSIONAL RELATIONS

- MSMS works to assure physician input in state public health policy through representation on state task forces and committees, such as the Expert Committee on AIDS and the Task Force on Infant Mortality.

- MSMS provides model constitution and bylaws and advice to component societies on developing their own constitution and bylaws.

- MSMS advises specialty societies on how to qualify for specialty representation in the MSMS House of Delegates.

- MSMS serves as an ombudsman for physicians having problems with peer review organizations.

- MSMS recognizes physicians who have assumed national leadership roles, provide leadership to non-medical organizations, and for other achievements.

- MSMS honors its members who have been physicians for 50 years.

ETHICS

- MSMS serves as sole appellate power at state level in all matters relating to ethics, professional conduct, mediation and discipline of members of component societies.

- MSMS responds to questions from physicians and the public on medical ethics.

Whom To Call At MSMS Headquarters

Executive Director: Bruce W. Ambrose
Managing Director: William E. Madigan

Address changes	Peg Berry
Advertising (in *Michigan Medicine*)	Sheri Greenhoe
AMA Delegation	Bruce Ambrose
Annual Scientific Meeting Program	Sherry Fent
Arbitration	Richard Campau
Auto Lease Plan	Wayne Burmeister
Blue Cross Blue Shield/Third Party Payors	Thomas White
Board of Medicine	Kevin Kelly
Continuing Medical Education	
Accreditation	Katie Brewbaker
Category I Calendar (in *Michigan Medicine*)	Joyce Crum
MSMS-Sponsored Conferences	Sherry Fent
Dues Billing & Payment	Peg Berry
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Graduate Medical Education	Sherry Fent
HMOs/PPOs	Thomas White, Debbie Zannoth
Hospital Medical Staff Relations	Thomas White
Impaired Physicians Program	Katie Brewbaker
Jail Health Project	Richard Campau
Judicial Commission	Katie Brewbaker
Legislation	Kevin Kelly
Loss Prevention, Risk Management	Richard Campau
Maternal Health Conference	Sherry Fent
Medicaid	Mary Anne Ford
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Medical Care Costs	Debbie Zannoth
Medical Ethics	Katie Brewbaker
Medicare	Debbie Zannoth
Medigram	Judy Marr
Member Services (Including insurance programs)	Wayne Burmeister
Membership Records	Peg Berry
Michigan Association for Medical Education	Viola Heins
Michigan Doctors Political Action Committee	Kevin Kelly
Michigan Chapter, American College of Surgeons	Viola Heins
Michigan Medicine (MSMS Journal)	Judy Marr, Sheri Greenhoe
Michigan Society of Anesthesiologists	Caroline Rich
Michigan Society of Internal Medicine	Caroline Rich
Michigan Society of General Surgeons	Caroline Rich
Michigan Society of Pathologists	Viola Heins
Michigan Society of Respiratory Therapy	Caroline Rich
MSMS Auxiliary	Viola Heins
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MSMS House of Delegates Agenda and Schedule	Richard Campau
MSMS Meeting Facilities	Linda Munson
MSMS Travel Programs	Donna Farougi
Patient Information, MSMS PR Materials	Kirk McMurray
Peer Review Organization of Michigan (PROM)	John Richards
Physician Legislative Network	Daniel Farhat
Physician Service Group, Inc.	John Richards
Practice Management	John Richards
Professional Liability Insurance	Richard Campau
Public Health Liaison	Mary Anne Ford
Public Relations	Sherry Wellman
Specialty Societies	Sherry Wellman

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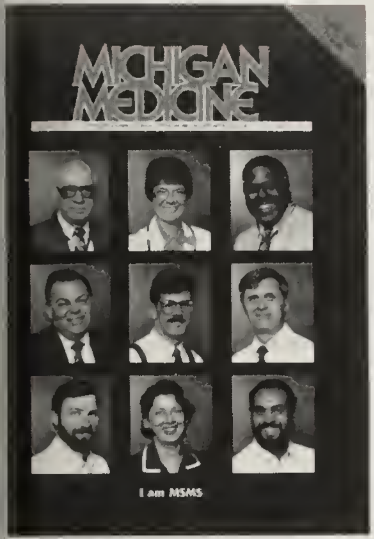
MICHIGAN MEDICINE



bout the cover: We don't ive to tell you who that is the cover. Look closely — you recognize that person ɔw? It's you, doctor. You are SMS! **Photos by Kim uffman.**

next month's issue of ***ichigan Medicine:*** A behind-e-scenes look at the new niversity Hospital in Ann rbor.

pecial Report

26 MSMS is *not* a building in East Lansing. It is *not* a staff that works on behalf of physicians in areas like government relations, communications, health care financing and education. And MSMS is *not* a mechanism through which physicians can purchase insurance at group rates.

Well, then, exactly what *is* it? MSMS is representation. It is influence and it is connections. It is the collective voice of more than 11,000 Michigan MDs. And that voice is heard.

That voice is *your* voice. The faces on the cover of this journal belong to you and your colleagues. *You* are MSMS.

What does that mean? Read what it means to some of your colleagues in this Special Report. Find out why they say, "I am MSMS." Also find out who serves on the more than 50 committees and task forces that plot the MSMS course. Read about how far we've come in the past 20 years. Find out where your dues go, what the AMA has done for you lately, and why it is imperative that young physicians and FMGs participate in organized medicine. Find out, too, why your spouse should join the MSMS Auxiliary.

And, to remind you of the many, many accomplishments MSMS members have achieved, we have published a special pull-out section at the front of this issue of *Michigan Medicine.* Those 109 accomplishments printed there really are 109 reasons why you should belong to MSMS; Busharat Ahmad, MD; Herb Auer; Cathy O. Blight, MD; Cecil R. Jonas, MD; Robert E. Paxton, MD; Shirley Prust; Mitchell A. Rinek, MD; Marsha M. Rohrer, MD; Krishna K. Sawhney, MD; Michael J. Sullivan, MD; Frank B. Walker, MD.

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By John W. Hall, MD

What we really need is. . .

Hall

We Americans have always enjoyed competition. It is part of our society from Little League through friendship center bingo. This same competitive atmosphere has been part of our health care system. Physicians have fought to have the largest practice. Hospitals bragged about the newest, biggest or most expensive. Insurance companies made competitive bids for our liability insurance business.

However, the atmosphere was such that there were winners, but no losers. Relative physician under-supply held out the prospect of a comfortable living to all competent physicians. Hospitals with less than 100 percent occupancy were still financially successful. With cost-plus financing, new equipment and technical advances were still available to all communities. Liability insurance was always available at modest cost.

But the rules are changing. New graduates now find that the roadside banners read, "This town has enough doctors!" Liability insurance companies don't want any more business. Forecasters predict that 30 percent of our hospitals will go bankrupt in the next few years. With more physicians competing for a small prospective payment pool, the living is definitely less comfortable. It is now possible to be a good hospital and a competent physician — but to be a loser in the competitive game of medicine.

What can we do?

What can we physicians do to give ourselves that best chance for survival in this changing jungle? We need a group that unites us to offer the greatest possible leverage in influencing health care policy decisions. We need an organization that works with the educational system to tailor the physician supply to the societal needs for medical care. We need an organization that can work with the legislature and the insurance industry on a solution of the malpractice crisis and on comprehensive tort reform. We need a group that offers extensive business services and benefit packages that help us maximize the yield of our business dollars. We need some friends with sympathetic ears that will listen to our problems, give us the benefit of their experience and offer alternative solutions to our problems. We need to hone our competitive skills while still maintaining the highest quality medical care and professional demeanor.

What we need now more than ever is . . . the Michigan State Medical Society. ☐

Doctor Hall, Petoskey urologist, is a member of the MSMS Board of Directors, and is chairman, MSMS Committee on Publications.

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for Michigan physicians about action
the Michigan State Medical Society a
contemporary issues, with special em
phasis on socio-economics, legislatio
and news about medicine in Michiga

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n limiting ontingency fees

cently the trial attorneys'
p lobbyists bragged that they
ere able to thwart tort re-
rm legislation in all but three
ates and have an excellent
ance to stop federal legisla-
on because of the high attor-
y representation in the Con-
ess. Their strategy now is to
ait out the "crisis" and then
sume pressure for more
nerous awards and a broader
bility definition.

There are those in govern-
ent who feel the liability cri-
is the number one problem
our country. At the recent
overnors Conference, Utah's
ov. Norman Bangerter stated
at the two most important
ings in liability reform are to
p contingency fees and
wards. The contingency fee
as added to the common law
hich came mostly from En-
and and France and formed
e basis of our Constitution.
e contingency fee is out-
wed in all other countries of
e world. To barter for a per-
ntage of a plaintiff's fee or
incite litigation is consi-
red unethical and unlawful
d is called barratry. Many
el that the contingency fee is
e main cause of the liability
oblem in the United States
cause where it is not al-
wed, the problem that we
e seeing here does not exist.

Ten years ago I chaired the
edical Malpractice Action
mmittee which tried to peti-
on enough signatures for a
llot proposal to limit contin-
ncy fees in malpractice
ses. We obtained about one-
lf of the necessary 260,000
mes. We received no sup-
rt from MSMS for our drive.
we had won, I am sure the
bility problem would be
fferent in Michigan. At that
ne, Indiana and California
ere able to get legislation for
sliding scale of contingency
fees and a cap on awards, all of which passed Supreme Court review. Their insurance rates now reflect their success.

Gerald H. Mandell, MD, in a recent letter in *Michigan Medicine* asked, "Is the liability crisis so bad as to surrender our heritage of Constitutional government and should a Constitution address salaries and fees, and should we attempt to restrict the fees of any professional?" The Constitution does describe fee arrangements in some states. As far as restricting a professional's fees, I think that any practicing physician is aware that fees are restricted under all government programs, most insurance company programs, and that severe legal penalties are applied in some states for "extra billing" of patients beyond insurance allowances. Doctors fees are also being published in some states without their permission, and essentially no recognition is given for an increase in physician fees because of the incredibly increased cost of liability insurance.

Toward a referendum

When we organized the Citizens Liability Action Committee, it was to complement the efforts of our legislators who were trying to effect tort reform legislation. They advised us that we should focus on the one important issue that could not be handled by them—limit contingency fees. They stated that this important issue would not be brought up by the legislature and could be accomplished by a referendum. It would provide leverage for them to act if the necessary signatures for a ballot proposal were obtained. We failed to get the necessary signatures for the 1986 election, but we can apply the 200,000 signatures we have to the 400,000 needed for the 1988 election. We now have the active support of the Michigan State Medical Society and we hope that citizens will help us with the petitions and the financial support needed for this most important step towards relieving the liability crisis.

The opportunity for citizens to change the law by way of a ballot proposal is one of the great freedoms demonstrated in our democracy. We have the opportunity to help Michigan by changing outmoded laws to allow producers of goods and service to flourish as before.

Alfred B. Swanson, MD
Chairman
Citizens Liability Action
Committee

I am MSMS

That is the theme of this special membership issue of *Michigan Medicine*. Save it for future reference regarding MSMS committees, dues distribution, the benefits of membership in organized medicine and in the Auxiliary, and more.

Five of your colleagues open this Special Report by sharing their thoughts on MSMS membership. Each joined organized medicine with certain expectations, and each has found personal meaning in continued involvement. Maybe one of them is telling *your* story. . .

I am MSMS

Jonas

By Cecil R. Jonas, MD

When I started practice in 1969 there was scant advice or material readily accessible to the young graduate attempting to start a medical practice.

Some good advice I clearly recall urged me to become a member of the local and state medical societies. Membership, at that time, was a proforma exercise. But, over the years, I became more interested in the need for and the advantages of belonging to an organized professional group on the local, state and national levels.

The experience has been a satisfying one. The Michigan State Medical Society has attempted to balance the somewhat conflicting interests of physicians from various areas in the state. It has provided the needed forum where doctors sharing common practice problems can come together to address their concerns and arrive at rational decisions.

Complex times

Medical practice has become fantastically complex in recent times and the stresses on the physician require a higher level of commitment and a greater degree of awareness than ever before. On any given day, almost as many hours are spent on problems on organization, economics and finance as on the cognitive and surgical skills of medical practice.

The practicing physician is buffeted by the stormy winds of social and economic change. The public perception of the practice of medicine has undergone tumultuous contortions, and the physician is caught up in a whirlwind that threatens to destroy his credibility, his ability to cope and, even worse, his entire financial and professional future.

The changes that have occured in the past five years have not always been proposed and formulated with th points of view of our profession paramount. Indeed, the profession has found itself reacting to initiatives by heal care managers, politicians, economists and social engineers. I am advised, not asked, to restructure my entir approach to health care delivery to suit the mandates of often unknowing and uncaring political processes.

This needs to be changed. The collective efforts of *all* physicians become necessary to create consensus for both solution and action.

MSMS has, in my opinion, made plausible efforts to define the peculiar problems of health care delivery in the Detroit area. I want to see thi continue. I urge my colleague to join me in supporting this effort.

MSMS membership should b rewarding. Mine has been. I plan to continue to work with MSMS as it addresses the complicated agenda for health ca delivery in Michigan.☐

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MSMS

Sullivan

By Michael J. Sullivan, MD
Resident

The major factor behind my active involvement in the ichigan State Medical Society as my lack of knowledge bout important issues facing e medical profession. The pidly changing environment f medicine is confusing nough for practicing physi- ans who deal with the anges on a daily basis. But hysicians-in-training and oung physicians generally do ot even understand the terminology much less the ramifica- ons.

We feel threatened by this changing environment. We continually hear the discontentedness expressed by our mentors regarding the difficulties facing physicians and their practices today. We see medicine being run more like a business, regulated by outside groups.

This definitely is not how I envisioned the practice of medicine prior to choosing it as my career. Unfortunately, the quality of patient care suffers is this kind of environment. But, as a practicing physician in the years to come, I am going to have to work in this environment.

I feel strongly about preserving the quality of medical care in this country. For me to talk intelligently as a patient advocate in support of the practice of medicine, I need to understand the issues. My involvement in the Michigan State Medical Society has given me the opportunity not only to learn about and understand, but to work with these issues. I have an opportunity to work side by side with my mentors in situations where my opinions and concerns are respected and my enthusiasm rewarded.

The rewards include our ability, with the support of physician groups, patient groups, and the diligent work by the Michigan State Medical Society, to preserve and maintain the highest standards of care for our patients in Michigan. This is a continuing battle. We are obligated to fight it for the sake of our patients. No group other than physicians knows what is best for medicine.

I no longer fear for the future of medicine because I know that through MSMS I have acquired the tools and understanding to face the changes which will affect the way I practice. In this way, through my involvement in MSMS, I have received far more that I could ever imagine to return.☐

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MSMS

Rohrer

By Marsha M. Rohrer, MD

I am a family physician and an Associate Director of the parrow Hospital Family Prac- ice Residency Program in Lan- ing. I maintain a clinical prac- ice which includes an active bstetrical service, I teach resi- lents and students, provide he medical direction for the ngham County Health Department's Family Planning/Prenatal linics, and administrate the peration of the Lansing Family Practice Center for Sparrow Hospital. I have been in practice for eight years, including one year of private practice in Mason, prior to joining the faculty at Sparrow.

I joined MSMS as a resident nine years ago, when I joined the Ingham County Medical Society. At the time, I was encouraged to participate in organized medicine by Pat Crow, when he was the Director of the Sparrow Residency. Pat felt very strongly that membership in the medical societies was an important component of medical practice.

At this juncture in my career, I wholeheartedly agree that membership in the local, state and national medical societies is a critical facet of current practice. Speaking through membership in MSMS is the only way individual physicians in Michigan can effectively express their views, either to large numbers of other physicians or to other politically important organizations such as the state legislature or the federal government. Politics is "who gets what, when and how," and American physicians are clearly getting less of "it" than at any time in the last fifty years.

Now more than ever, it is critical that physicians work together to do what we think is right, both for the health of our patients and for the health of the economy of our state and country. Expressing my viewpoint through the committee structure of MSMS, as well as at the county society level, has allowed me to have influence in situations that would not have been accessible to me as an individual.

In addition to the potential for effective political action through membership and par-

Continued on next page

ROHRER/Continued

ticipation in MSMS, my membership has offered me the opportunity to interact with many physicians, in varied specialties, from all over the United States. This interaction has been educational, intellectually stimulating, and just plain fun. My participation on a number of committees has taught me valuable organizational skills, which have transferred to many areas of my life. The MSMS staff has been a very helpful resource for me on numerous occasions, as well. And, MSMS publishes a large volume of excellent educational information that has been very helpful, both to me and to my patients.

In summary, I highly recommend membership *and* active participation in our medical societies, at the local, state and national levels. By working together, we can keep our sanity and influence the changes that are swirling around us in medicine.☐

I am MSMS

Sawhney

By Krishna K. Sawhney, MD

Thank God for Wayne County Medical Society answering service. I know, you are wondering what I am talking about. It was quite some time ago that I needed WCMS answering service and couldn't get it until I became a dues-paying member of MSMS and WCMS. That is how I became a member of MSMS, otherwise, I really had no plans to join.

After I did, I expected all r problems even remotely related to the practice of medicine to go away. I expected my office to be in to shape, the secretaries to be up-to-date, all patient payments to be received on tim dishes done, and the mortga paid. I expected BCBS to sen me the revenue on time, Me care to love me, HMOs, PPO IPAs to go away, and never t hear a word about liability. Was I in for a surprise! Thing just didn't change as I had ex pected and I asked myself, what has MSMS ever done fo me? I was even quite vocal about it. I blamed anything that was not good in my life on my medical society. This was quite some time ago.

Looking back, I smile at m ignorance. I expected MSMS have all of the answers all of the time. I was naive. No one society can take care of all t problems around you even if you are a dues-paying memb in good standing and a sustai ing AMPAC member.

But it took me time to understand this fact. I had neve made any effort to come to know the medical society. I neither understood the purpo nor the workings of this society and I didn't realize the power and strength of so ma physicians working together for a common goal.

The only game in town

It was in the late seventies when changes in all aspects medical care were rampant. Liability problems were haunt ing us, HMOs, PPOs, IPAs we knocking on our doors, and PROs and DRGs were coming. Finally I realized the only wa these changes can be properl shaped is with the help of ou medical society. This is the only game in town. This is th only voice anyone in Washin ton or Lansing listens to. This is the only voice which can speak boldly and jointly for most of the physicians in Michigan (85 percent of phys

Young physicians unite

MSMS has established a Young Physicians Task Force to consider forming an MSMS Young Physicians Section. The purpose of the MSMS Young Physicians Task Force is to provide a direct means for young physician members of MSMS (age 40 and under) to participate more effectively in organized medicine. Richard A. Stone, MD, from Macomb County is the chairman of the task force. Their first organizational meeting is scheduled for Wednesday, October 29 at MSMS.

WHNEY/Continued

ans are members of MSMS).

Coming to know MSMS was eye-opening experience. e amount of work, time, and fort being put in by the staff d its leaders is trememdous. is run very openly and in a mocratic fashion. I believe e general membership probay doesn't even know how uch work our society does!

It is impressive to see MSMS adership play its role on the tional scene. For example, ght now we have John Coury, D, as president of AMA, omas Berglund, MD, as president of AMPAC and other disnguished members holding portant AMA positions. The t is long and impressive. It is ear our society is playing an tive role in shaping AMA's tional policy.

At the state level, MSMS is volved in every aspect which fects a practicing physician. is includes everything from blishing *Medigram*, *Michigan edicine* and patient information pamphlets to making sure at all the bills coming to the ichigan Legislature are viewed. Believe me, it is a avy task and MSMS does it ry well.

esh ideas needed

Like any democratic organition, what MSMS needs most the involvement of its mem rs. Fresh ideas are always eded to keep a society gog at full speed to meet its als.

Occasionally, when I feel SMS could have done better, quickly remind myself that SMS is me, MSMS is us. We l share responsibility in runng it efficiently and smoothly it can accomplish the goal very time. As we all share the leasure of its accomplishents, we all must share qually in its failures. We must ctivate; we must participate; lot needs to be done. That's ow I feel—I am MSMS and I m proud of it.☐

I am MSMS

Rinek

By Mitchell A. Rinek, MD

My involvement in organized medicine goes back to my residency in the mid-1970s. One of my favorite professors, the late Christian Radecliffe was quite active in the Johnson County Medical Society, where the University of Iowa Hospital is located, as is the Iowa State Medical Society. He piqued the interest of several residents and we attended the county medical society meetings on a relatively regular basis.

One of Doctor Radecliffe's major points to us was how several quasi-medical groups and chiropractors had pulled themselves into prominence and gained considerable political clout through dramatic organizational efforts. This opened my eyes to the interactions of a county medical society within the sphere of the state medical society, and sharpened my interest in becoming involved.

When I came to the Lansing area, I decided to pursue my goal of becoming a private practicing Dermatologist. As a specialist, and non-hospital physician, I had to take major steps to get involved with a majority of people who were hospital-based and part of larger groups. The county society was a "natural" toward this end, and I have had interaction and good friendships with many physicians whom I would not otherwise have met in my daily practice of medicine.

A major focus of my interest, started on the local level, spread to the state level. That interest is in the political and legislative aspects of the Michigan State Medical Society. I became chairman of the Ingham County Medical Society Legislative Committee five years ago, and have become active on the MSMS Committee on Legislation and Regulation. My active involvement with Will Maldonado, MD, and Fred Minkow, MD, as well as with Bruce Ambrose and Kevin Kelly of the MSMS staff, have been some of the most rewarding aspects of my involvement.

The legislature is becoming more aware of physicians these days in light of the liability situation. In turn, however, there are many pieces of legislation that influence medical practice that need to be considered by all physicians on a *regular* basis. Becoming involved in this area and alerting and involving others has shown me a little bit more of the *real* world in which medicine participates. I have learned to appreciate the fact that small groups of organized physicians *can* exert a major influence on the legislative process. Plus, we can develop good friendships with legislators that can be rewarding on a personal basis.☐

MSMS committees shape futur

COMMITTEE ON AGING

This Committee examines the health status of senior citizens, issues regarding financing of the Medicare program and long term health care for the elderly. Activities include advocating preventative medicine programs and providing physicians with an overview of the medical, social and psychological needs of the aged patient. The Committee works with many community organizations and the State Office of Services to the Aging.

William T. Bateman, MD, Chairman, Kalamazoo
Mrs. Pat Allen, Battle Creek
Harvey M. Andre, MD, Grand Rapids
Frank S. Blumenthal, MD, Detroit
Diane A. Culik, MD, Detroit
Phillip M. Green, MD, Kalamazoo
Robert A. Holmes, MD, Lansing
Brooker L. Masters, MD, Fremont
James G. O'Brien, MD, East Lansing
Ashok R. Sonnad, MD, Vestaburg
Frederick C. Swartz, MD, Lansing
Robert J. Toteff, MD, Detroit
Sumer D. Verma, MD, East Lansing
Richard H. Wakuiat, MD, Petoskey
Thomas J. Northey, Consultant, Lansing
James R. Tarrant, Consultant, East Lansing
Deborah Zannoth, Staff Assistant

TASK FORCE ON AIDS EDUCATION

The purpose of the Task Force is to develop strategies for educating physicians about AIDS and to coordinate MSMS efforts in physician and public education with those of the Michigan Department of Public Health.

Frederick W. Bryant, MD, Chairman, Royal Oak
E. Joseph Alberding, MD, Portage
David S. Davenport, MD, Kalamazoo
William E. Dougan, MD, Detroit
John F. Fennessey, MD, Grosse Pte.
Evelyn J. Fisher, MD, Detroit
Douglas A. Mack, MD, Grand Rapids
David B. Martin, MD, Traverse City
David R. Rovner, MD, East Lansing
Mary Anne Ford, Staff Assistant

MSMS TASK FORCE TO STUDY ALTERNATIVES TO THE TORT SYSTEM

This Task Force studies alternatives to the tort system for resolving allegations of malpractice.

William P. McCabe, MD, Chairman, Grosse Pte. Woods
Domenic R. Federico, MD, Grand Rapids
Reed K. Freidinger, MD, Charlevoix
Thomas A. Kwyer, MD, Dearborn
John H. McLaughlin, MD, Birmingham
Louis E. Sanford, MD, Belding
Gary S. Smith, MD, Midland
Alfred B. Swanson, MD, Grand Rapids
Richard M. Campau, Staff Assistant

COMMITTEE ON AWARDS

The Committee supervises the MSMS award program and makes recommendations to the Board of Directors.

Frank B. Walker, MD, Chairman, Grosse Pte. Farms
Robert M. Leitch, MD, Battle Creek
Thomas C. Payne, MD, Lansing
Katie Brewbaker, Staff Assistant

COMMITTEE ON BIOETHICS

The Committee considers questions about scientific, medical, moral, ethical and political concerns dealing with the beginning of life and the ending of life which have raised increasing problems for physicians and therefore MSMS.

Frederick W. Bryant, MD, Chairman, Royal Oak
Howard A. Brody, MD, East Lansing
Mrs. Betty Drew, Bloomfield Hills
Gary S. Gustafson, MD, Berkley
Clifford S. Hale, MD, Lansing
James T. Harrison, MD, Grand Ledge
John V. Hartline, MD, Kalamazoo
George F. Newman, MD, Dearborn
Evan J. Reinders, MD, Muskegon
Marguerite Shearer, MD, Dexter
Kornelius Van Goor, MD, Grand Rapids
Sherry N. Wellman, Staff Assistant

BOARD OF MANAGERS

The Board of Managers oversees the management of the Capital Reserve Fund, the Creative Reserve Fund and the management of MSMS buildings and grounds.

Leland E. Holly, II, MD, Chairman, Muskegon
Jack L. Barry, MD, Saginaw
Justin L. Sleight, MD, Lansing
Timothy M. Talbott, MD, Grand Rapids
Arthur A. Ulmer, MD, Grosse Pte. Shores
Fred W. Whitehouse, MD, Detroit
Richard M. Campau, Staff Assistant

COMMITTEE ON CHILD ABUSE AND NEGLECT

The MSMS Committee on Child Abuse and Neglect was established as a focal point for medical concerns related to child abuse. Its purpose is to increase physician awareness about the problems of child abuse and to initiate or participate in programs to promote the detection and reporting of child abuse.

Barbara Meyer Lucas, MD, Chairman, Detroit
Alexa Canady, MD, Detroit
Mrs. Dottie Csonka, Essexville
Ruben S. Kurnetz, MD, Birmingham
Myrtle S. McLain, MD, Grand Rapids
Clyde L. Owings, MD, Ann Arbor
Douglas A. Sargent, MD, Grosse Pte. Farms
Jack M. Stack, MD, Alma
Mark H. Tucker, MD, Battle Creek
Dennis A. Wagner, MD, Sanford
Ray E. Helfer, MD, East Lansing, Consultant
Daniel R. Farhat, Staff Assistant

ADVISORY COMMITTEE ON COMMUNICATIONS AND PROFESSIONAL RELATIONS

This Committee develops and oversees all public relations and public service activiti It provides physician input to the program suggestions and activities advanced by ou side consultants and MSMS staff.

Richard H. Gascoigne, MD, Chairman
Susan E. Adelman, MD, Detroit
Robert C. Arends, MD, Birmingham
Mrs. Nancy Crandall, Muskegon
Robert L. Cross, MD, Flushing
Richard S. Duff, MD, Rochester
Clyde R. Flory, Jr., MD, Lansing
Reed K. Freidinger, MD, Charlevoix
C. Thomas Kelso, MD, Spring Lake
Raymond R. Komray, MD, Muskegon
Fred E. Patterson, MD, Jackson
Thomas C. Payne, MD, Lansing
E. James Potchen, MD, East Lansing
M. Gary Robertson, MD, Grand Haven
Richard A. Stone, MD, Mt. Clemens
Linda L. Martin, Consultant, Lansing
Sherry N. Wellman, Staff Assistant

COMMITTEE ON CONTINUING MEDICAL EDUCATION ACCREDITATION

This Committee maintains standards to assure that quality CME activities are availab to Michigan physicians through review, evaluation, and accreditation of continuin medical education providers in the state.

Donald J. Aiken, MD, Chairman, Okemos
Richard F. Willis, MD, Vice-Chairman, Alpe
Gail I. Bank, PhD, Detroit
Norman J. Bolton, MD, Detroit
James C. Breneman, MD, Galesburg
Allen D. Damschroder, MD, Petoskey
Roland G. Hiss, MD, Ann Arbor
Mark D. Kolins, MD, Grosse Pointe
Joseph F. Marshall, MD, Saginaw
John W. Moynihan, MD, Dearborn
Michael W. Radke, PhD, Lansing
Robert K. Richards, PhD, Grand Rapids
Victor V. Rozas, MD, Alma
Joseph A. Sentkeresty, MD, Grand Rapids
Robert L. Tupper, MD, Grand Rapids
W. Donald Weston, MD, East Lansing
Charles L. Zeller, MD, Kalamazoo
Katie Brewbaker, Staff Assistant

COMMITTEE ON CONTINUING MEDICAL EDUCATION PROGRAMMING

The Committee develops, conducts, and supervises Category I programs in Michigan t serve the continuing medical education needs and interests of physicians. It also is empowered to co-sponsor programs which meet the CME criteria for Category I.

David R. Rovner, MD, Chairman, East Lansing
John R. Addy, MD, Lansing
Rudi Ansbacher, MD, Ann Arbor
Frederick W. Bryant, MD, Royal Oak
Robert E. Birk, MD, Detroit

derick W. Bryant, MD, Roya. Oak
hard E. Dean, MD, East Lansing
de R. Flory, Jr., MD, Lansing
chael J. Giacalone, Jr., MD, Flint
chael Iacobellis, MD, Allen Park
rry Kinzel, MD, Hancock
vid C. Leach, MD, Detroit
hard A. Lemmer, MD, Kalamazoo
even E. Minnick, MD, Detroit
orge L. Royer, Jr., MD, Kalamazoo
n C. Stryker, MD, Detroit
go M. Uhland, MD, Saginaw
nes R. Tarrant, Consultant, East Lansing
erry L. Fent, Staff Assistant

OMMITTEE ON ONSTITUTION AND BYLAWS

s standing committee reviews proposals amend the MSMS Constitution and Bylaws d presents recommendations for appropri- action by the MSMS House of Delegates. serves as a reference committee during House of Delegates meeting.

l G. Moehn, MD, Chairman, Mt. Clemens
bert D. Allaben, MD, Wayne
omas F. Higby, MD, Fowlerville
rray G. Kling, MD, Detroit
nes E. McGillicuddy, MD, Lansing
n H. McLaughlin, MD, Birmingham
er B. Sherman, MD, Eaton Rapids
hard Weber, Consultant, Detroit
lliam E. Madigan, ex officio, East Lansing
da L. Davis, Staff Assistant

OMMITTEE ON STATE EGISLATION AND EGULATIONS

is Committee monitors and influences chigan legislation through the legislative cess, and monitors and responds to chigan government rules and regulations they are promulgated.

derick V. Minkow, MD, Chairman, Bloomfield Hills
n R. Addy, MD, Lansing
bert D. Allaben, MD, Detroit
chael T. Bergeon, MD, Saginaw
thy O. Blight, MD, Flint
na M. H. Broecker, MD, Grand Rapids
vid R. Calver, MD, Bloomfield Hills
s. Lois Duhamel, Rochester
n A. Feemster, MD, Detroit
hard P. Heuschele, MD, Saginaw
hard P. Horsch, MD, Livonia
rothy Kahkonen, MD, Detroit
s. Linda Kelly, Muskegon
chael S. Kobernick, MD, Lathrup Village
rk D. Kolins, MD, Grosse Pte.
chael J. Kush, MD, Three Rivers
nes E. MacVicar, MD, Kalamazoo
lfred E. Maldonado, MD, Lansing
nes M. McGillicuddy, MD, Lansing
arles L. Oppy, MD, Roscommon
nifred A. Oyen, MD, Midland
n P. Papp, MD, Grand Rapids
n C. Parker, MD, Jackson
d E. Patterson, MD, Jackson
anwada S. Rao, MD, Detroit
tchell A. Rinek, MD, Lansing
rguerite Shearer, MD, Dexter
rvin L. Starman, MD, Southfield
llard S. Stawski, MD, Grand Rapids
omas E. Stone, MD, Muskegon
illip B. Storm, MD, Petoskey
nk G. VanDeventer, MD, Harper Woods
arles C. Vincent, MD, Detroit
nk B. Walker, MD, Grosse Pte. Farms
David Wilson, MD, Kalamazoo
rnard J. Woodley, MD, Trenton
ger F. Mecum, Consultant, Detroit

Richard D. Weber, Consultant, Detroit
Milton Zaagman, Consultant, Lansing
Kevin A. Kelly, Staff Assistant

TASK FORCE ON CONCERNS OF FOREIGN MEDICAL GRADUATES

This Committee establishes a relationship between local FMG organizations and MSMS, publicizes the activities of the Task Force, serves as a resource to FMGs or potential FMGs seeking information or assistance, and proposes to the MSMS Board of Directors new programs designed to serve the needs of FMGs and increase their participation in MSMS.

Busharat Ahmad, MD, Chairman, Marquette
Jaime V. Aragones, MD, Rochester
Mutjaba Husain, MD, Detroit
Appa Rao Mukkamala, MD, Flint
Marguerite Shearer, MD, Dexter
Dhanwada Sudhaker Rao, MD, Detroit
Devendra K. Sharma, MD, Tawas City
Pamilia Sinha, MD, Southfield
A. L. Suarez-Martinez, MD, Dearborn
Arthur A. Ulmer, MD, Grosse Pointe Shores
Walter R. Woodhouse, MD, Flint
Wayne E. Burmeister, Staff Assistant

TASK FORCE TO IDENTIFY GRANT PROPOSALS TO BE SUBMITTED TO THE MICHIGAN HEALTH CARE EDUCATION AND RESEARCH FOUNDATION

Leland E. Holly, II, MD, Chairman, Muskegon
Robert W. Black, MD, Detroit
Fred E. Patterson, MD, Ann Arbor
Richard L. Rapport, MD, Flint
Charles C. Vincent, MD, Detroit
Frank B. Walker, MD, Grosse Pte. Farms
William G. Anderson, DO, Consultant, Detroit
D. A. DeShaw, Consultant, Farmington
Frank J. McDevitt, DO, Consultant, Livonia
Bill Madigan, Staff Assistant

ADVISORY COMMITTEE ON HEALTH CARE POLICY

This Committee recommends MSMS policy on health planning. It encourages physician involvement in health planning issues, monitors activities of health systems agencies (HSA) and the Statewide Health Coordinating Council (SHCC) and assures physician input.

Kenneth J. Ray, MD, Co-chairman, Trenton
Fred E. Patterson, MD, Co-chairman, Jackson
Billy B. Baumann, MD, Pontiac
Robert B. Carbeck, MD, Ann Arbor
George R. Gerber, MD, Rochester
Denise G. K. Gray, MD, Detroit
John V. Hartline, MD, Kalamazoo
Terrell K. Hebert, MD, Grand Haven
D. Bonta Hiscoe, MD, East Lansing
Marguerite Shearer, MD, Dexter
Donald C. Smith, MD, Farmington Hills
Mary Anne Ford, Staff Assistant

STEERING COMMITTEE ON PROGRAM TO ASSIST IMPAIRED PHYSICIANS

The Steering Committee provides assistance to physicians who have problems related to emotional illness, alcoholism, or drug abuse. Education toward prevention, case finding, and intervention are major components of the program.

Carl A. Gagliardi, MD, Chairman, Dearborn
Michael Boyle, DO, Troy
John B. Bryan, MD, Royal Oak
Thomas L. Haynes, MD, Battle Creek
Robert H. Hydrick, MD, Grand Rapids
Bobbe J. Kelley, DO, West Bloomfield
William J. Kube, MD, Kalamazoo
Douglas W. MacDonald, MD, Oxford
Mrs. Cathie Martin, Traverse City
Joyce W. Mason, MD, Ann Arbor
Stephen C. Mason, III, MD, Ann Arbor
Tom R. Miles, DO, Traverse City
Richard A. Morin, MD, Ann Arbor
Robert Niccolini, MD, Detroit
John T. O'Connor, DO, Lansing
Russell F. Smith, MD, Whitmore Lake
Gerald A. VanderVoord, MD, East Lansing
Katie Brewbaker, Staff Assistant

JUDICIAL COMMISSION

The Commission has sole jurisdiction over matters of ethics, mediation, grievance, and discipline of MSMS members. It has authority to make binding interpretations of the MSMS Constitution and Bylaws and of component society bylaws, as well as rules and regulations governing such matters.

John H. McLaughlin, MD, Chairman, Birmingham
N. Warn Courtney, MD, Kalamazoo
Edwin H. Gullekson, MD, Flint
Murray G. Kling, MD, Detroit
Robert P. Lilly, MD, Livonia
Adam C. McClay, MD, Traverse City
George W. Morley, MD, Ann Arbor
Joseph L. Ponka, MD, Detroit
John C. Rienstra, MD, Grand Rapids
Krishna K. Sawhney, MD, Taylor
Richard Weber, Consultant, Detroit
Katie Brewbaker, Staff Assistant

LIAISON COMMITTEE WITH AUXILIARY

The Liaison Committee advises the MSMS Auxiliary, on request, regarding Auxiliary activities and problems. It also suggests projects the Auxiliary may wish to undertake.

R. Jack Chase, MD, Chairman, Grand Rapids
Dale R. Drew, MD, Pontiac
Peter A. Duhamel, MD, Rochester
Viola Heins, Staff Assistant

LIAISON COMMITTEE WITH BLUE CROSS BLUE SHIELD OF MICHIGAN

The Liaison Committee is a communication link to assist individual physicians in obtaining information concerning Blue Cross Blue Shield of Michigan's policies and procedures and to provide input to aid in the resolution of problems which may arise. The Committee also considers and provides input on major policy and professional issues related to BCBSM.

Susan E. Adelman, MD, Chairman, Detroit
Robert W. Black, MD, Detroit
Gerald F. Conway, MD, Royal Oak
Allen D. Damschroder, MD, Petoskey

Continued on next page

LIAISON WITH BCBSM/Continued

Henry M. Domzalski, MD, Detroit
James J. Humes, MD, Detroit
Charles N. Inniss, MD, Detroit
William B. Jensen, MD, Grand Rapids
Gary D. Maynard, MD, Kalamazoo
Richard L. Rapport, MD, Flint
Arthur A. Ulmer, MD, Grosse Pte. Shores
Larry J. Sell, MD, Consultant, BCBSM, Detroit
Fred R. Severyn, MD, Consultant, BCBSM, Detroit
David J. Barthel, Consultant, BCBSM, Detroit
Thomas E. White, Staff Assistant

LIAISON COMMITTEE WITH CORPORATE MEDICAL DIRECTORS

The Liaison Committee meets with medical directors of corporations to discuss common interests and recommend appropriate courses of action.

Richard H. Gascoigne, MD, Chairman, Adrian
Duane L. Block, MD, Dearborn
David W. Hills, MD, Benton Harbor
David Jacknow, MD, Detroit
Robert T. Nolta, MD, Warren
Kirk McMurray, Staff Assistant

LIAISON COMMITTEE WITH MEDICAL ASSISTANTS

The Liaison Committee advises the American Association of Medical Assistants, State of Michigan, on request, regarding medical assistant activities and problems. It also suggests projects the medical assistants may wish to undertake.

Joseph J. Tiziani, MD, Chairman, Ann Arbor
Arthur L. Brown, II, MD, Kalamazoo
Richard M. Czop, MD, Lansing
Anton Strocel, MD, Flint
Gordon F. Van Otteren, MD, Grand Rapids
Caroline Rich, Staff Assistant

LIAISON COMMITTEE WITH MICHIGAN DEPARTMENT OF PUBLIC HEALTH

The Committee works to improve information and communication channels among public health officers, practicing physicians, and the public on environmental and public health issues of mutual concern.

E. Joseph Alberding, MD, Chairman, Portage
Elaine L. Atallah, MD, Farmington Hills
Bradley T. Barnes, MD, Rochester
Mrs. Evelyn Dykewicz, RN, Flint
Robert H. Friedman, MD, Ann Arbor
Douglas A. Mack, MD, MPH, Grand Rapids
David C. Nolan, MD, White Cloud
A. Thomas Waytes, MD, Detroit
Kenneth E. Rowe, MD, Board Advisor
Mary Anne Ford, Staff Assistant

COMMITTEE ON MATERNAL AND PERINATAL HEALTH

This Committee strives to improve the care of the obstetrical patient and her newborn and to provide means for physicians, nurses, and others interested in maternal and perinatal health to discuss mutual problems and share ideas. It works in close cooperation with the state agencies and medical specialty organizations.

Robert W. Dustin, MD, Chairman, Dearborn
Lloyd A. Kammeraad, MD, Vice-Chairman, Grand Rapids
Silvio Aladjem, MD, Kalamazoo
Rudi Ansbacher, MD, Ann Arbor
C. Arch Brown, MD, Flint
Ralph A. Cram, MD, Albion
Preston V. Dilts, Jr., MD, Ann Arbor
Steven M. Donn, MD, Ann Arbor
Gerhard C. Endler, MD, Grosse Pte. Woods
Donald S. Frost, MD, Traverse City
James W. Gell, MD, Bloomfield Hills
John W. Hallitt, MD, Flint
John V. Hartline, MD, Kalamazoo
Douglas G. Kinne, MD, Petoskey
Mary J. Kokosky, MD, Dearborn
James G. Kornmesser, MD, Novi
Mrs. Pat Krapohl, Jackson
Don R. Krohn, MD, Southfield
Chang Y. Lee, MD, Detroit
Francis A. Locke, MD, Adrian
Robert P. Lorenz, MD, Royal Oak
Federico G. Mariona, MD, Detroit
Joseph P. Metz, MD, Flint
William H. Michaels, MD, Southfield
Joseph S. Moore, MD, Grand Rapids
Wallace G. Pearson, MD, Marquette
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TASK FORCE ON MEDICAL CARE COSTS

The Task Force considers and evaluates methodologies for containing the cost of quality health care, encourages cost awar ness, and develops cost effectiveness info mation for the practicing physician. The Task Force publishes articles on cost containment in *Michigan Medicine.*

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The Task Force reviews the professional liability climate in Michigan and the nation, is familiar with proposed reforms, and recommends appropriate legislative or other improvements.

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Linda Munson, Staff Assistant

TASK FORCE ON YOUNG PHYSICIANS AND ORGANIZED MEDICINE

The purpose of this Task Force is to look a establishing a state level of young physicians as a means of strengthening the direc and meaningful participation of young phys cians throughout the federation of the AM MSMS and the county societies.

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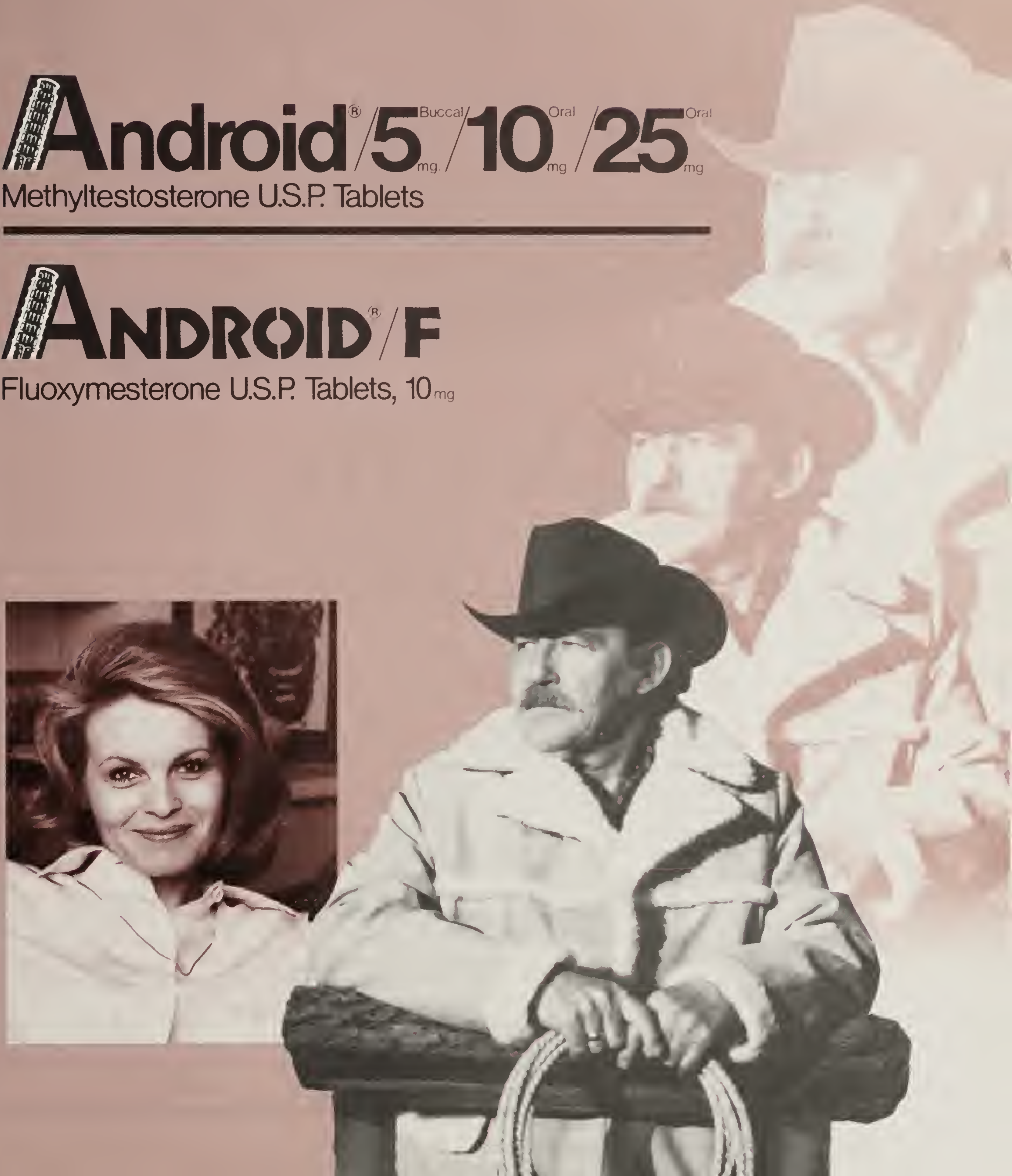

By Busharat Ahmad, M

FMGs have good reason to participate in organized medicine

While every practitioner wishes to be considered first as a physician, those who are graduates of medical schools outside the US and Canada face unique challenges and have special concerns. In recognition of this uniqueness, the AMA's Board of Trustees chartered an Ad Hoc Committee on Foreign Medical Graduates. In its report to the AMA's House of Delegates, the Committee made 30 recommendations based on a review of existing AMA policies affecting foreign medical graduates, an attitudinal survey, and an open hearing on issues and problems related to foreign medical graduates.

The Committee found it is clear that foreign medical graduates should actively participate in organized medicine. The first step is membership at all levels. Membership in the AMA is a crucial aspect of the need for involvement. The AMA, through its influence in Congress, the courts, federal regulatory agencies, the Educational Commission on Foreign Medical Graduates (ECFMG), the Accreditation Council for Graduate Medical Education (ACGME), the Federation of State Medical Boards (FSMB), the Joint Commission on Accreditation of Hospitals (JCAH), and many other organizations has substantial impact into policies which affect foreign medical graduates. Foreign medical graduates will increase their voice in AMA policies on issues of concern by belonging to the AMA; there is strength in numbers.

Proposed actions

Beyond membership, there is a clear need for foreign medical graduates to become active in organized medicine. Several of the Committee's recommendations propose actions to facilitate active involvement in organized medicine. For example, the Committee proposed that the AMA develop a listing of foreign medical graduates who are interested in becoming actively involved in organized medicine. This list would be distributed to medical societies throughout the nation for consideration in selection of nominees for councils and committees at all levels.

The Committee's recommendations addressed many aspects of the problems facing foreign medical graduates. Among its recommendations were:

- The AMA should oppose the use of accreditation standards for purposes of regulating physician manpower;
- AMA representatives to the ACGME, residency review committees and to the ECFMG should emphasize and support AMA policy opposing discrimination;
- The AMA should reaffirm and publicize existing policy that the first consideration in granting staff and clinical privileges in hospitals and other health facilities should be the ability of a licensed physicians to serve patients, not the race, creed, color, national origin nor medical school from which the physician graduated;
- The AMA should use its existing publications to highlight policies and activities of interest to FMGs, stressing the common concerns of all physicians;
- The AMA should publiciz its many relevant resources to member and non-member foreign medical graduates.

Awareness

The very fact that the AMA chose to charter and fund the Ad Hoc Committee on Foreign Medical Graduates is indicativ of the organization's awareness of and interest in the special challenges facing foreign medical graduates in these times of shrinking health care resources. The AMA is making a concerted effort to involve foreign medical graduates in organized medicine at all levels. Through membership and active participation in organized medicine, foreign medical graduates can harness the power of the AMA to address their unique concerns, as well as help the profession overcome the obstacles which will continue to face all physicians in the difficult years ahead.☐

Doctor Ahmad, Marquette ophthalmologist, is chairman of the MSMS Task Force on Concerns of Foreign Medical Graduates.

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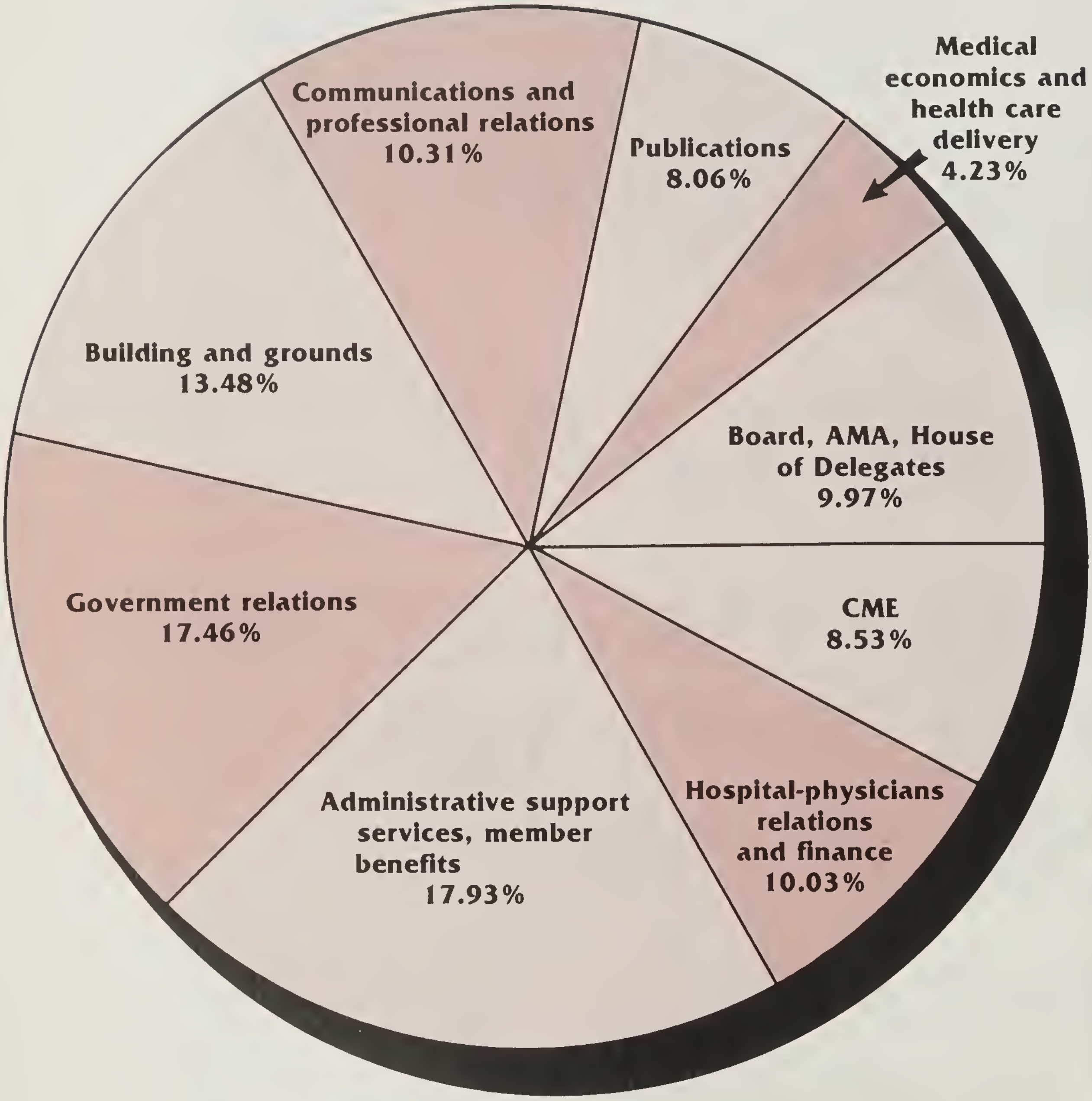
The Finance Committee acts on the recommendations of the MSMS Budget Subcommittee to the Finance Committee and spends many hours during the fall months analyzing every projected expense and revenue item. They obtain final approval for the budget from the MSMS Board of Directors.

The pie chart below illustrates the distribution of MSMS income from dues and other sources to MSMS program areas. It is published to give MSMS members a clearer ide of how MSMS revenues are spent.☐



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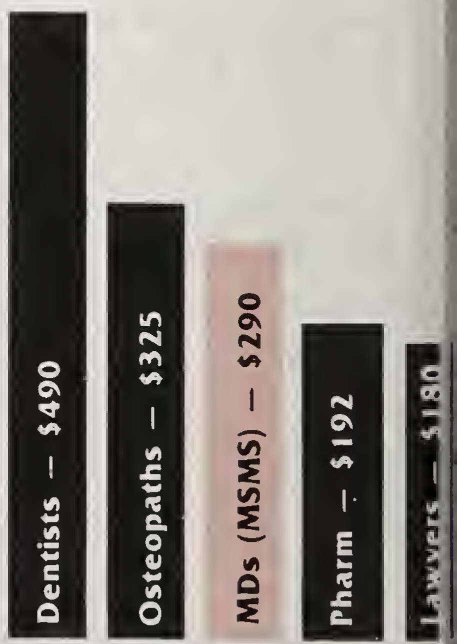

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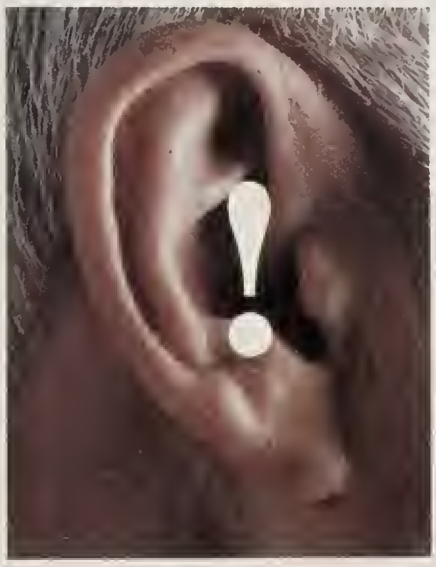

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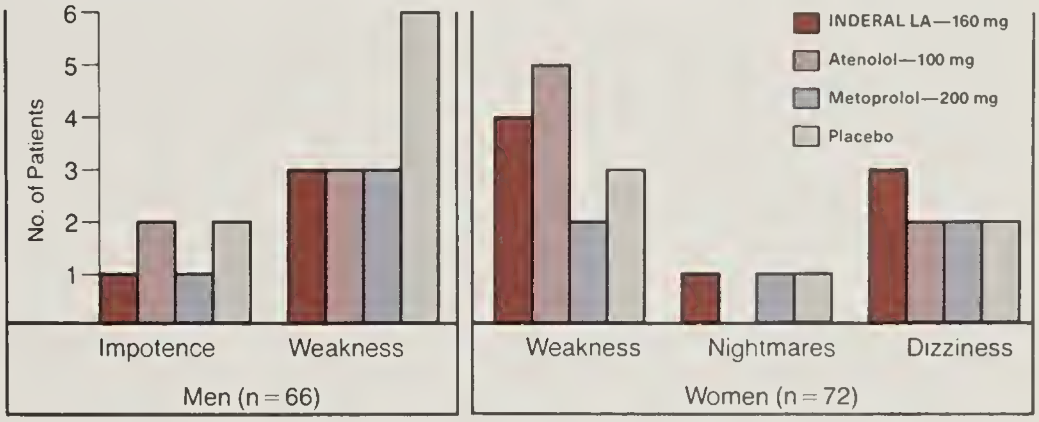

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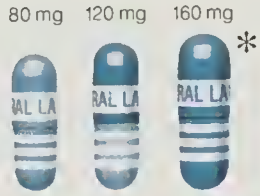

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INDERAL LA and INDERIDE LA Capsules should not be considered simple mg-for-mg substitutes for INDERAL and INDERIDE Tablets. Please see package circulars

CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL® LA): Propranolol is contraindicated in: 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS

Propranolol hydrochloride (INDERAL® LA): CARDIAC FAILURE Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or propranolol should be discontinued (gradually, if possible)

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction following *abrupt* discontinuance of propranolol therapy Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hyperthyroidism Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY· The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS INDERAL should be administered with caution, since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia In patients with impaired renal function, cumulative effects of the drug may develop

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma

Thiazides may add to or potentiate the action of other antihypertensive drugs Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported

PRECAUTIONS

Propranolol hydrochloride (INDERAL® LA): GENERAL Propranolol should be used with caution in patients with impaired hepatic or renal function Propranolol is not indicated for the treatment of hypertensive emergencies

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure Patients should be told that propranolol may interfere with the glaucoma screening test Withdrawal may lead to a return of increased intraocular pressure

CLINICAL LABORATORY TESTS Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs, such as reserpine, should be closely observed if propranolol is administered The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY· Long-term studie in animals have been conducted to evaluate toxic effects and carcinogenic potential In 1 month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was r evidence of significant drug-induced toxicity There were no drug-related tumorigen effects at any of the dosage levels. Reproductive studies in animals did not show ar impairment of fertility that was attributable to the drug

PREGNANCY· Pregnancy Category C Propranolol has been shown to be embryotox in animal studies at doses about 10 times greater than the maximal recommended huma dose. There are no adequate and well-controlled studies in pregnant women Propranol should be used during pregnancy only if the potential benefit justifies the potential risk the fetus.

NURSING MOTHERS Propranolol is excreted in human milk. Caution should be exe cised when propranolol is administered to a nursing mother.

PEDIATRIC USE: Safety and effectiveness in children have not been established

Hydrochlorothiazide: GENERAL· Periodic determination of serum electrolytes detect possible electrolyte imbalance should be performed at appropriate intervals

All patients receiving thiazide therapy should be observed for clinical signs of fluid electrolyte imbalance, namely Hyponatremia, hypochloremic alkalosis, and hypokalemia Serum and urine electrolyte determinations are particularly important when th patient is vomiting excessively or receiving parenteral fluids Medication such as digital may also influence serum electrolytes Warning signs irrespective of cause are· Dryness mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramp muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbance such as nausea and vomiting

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis present, or during concomitant use of corticosteroids or ACTH

Interference with adequate oral electrolyte intake will also contribute to hypokalemi Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect digitalis (eg. increased ventricular irritability). Hypokalemia may be avoided or treated b use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatmen except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is wate restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening In actual salt depletion, appropriate replacement is the therap of choice

Hyperuricemia may occur or frank gout may be precipitated in certain patients receivin thiazide therapy

Insulin requirements in diabetic patients may be increased, decreased, or unchange Diabetes mellitus which has been latent may become manifest during thiazid administration.

If progressive renal impairment becomes evident, consider withholding or discontinuin diuretic therapy

Thiazides may decrease serum PBI levels without signs of thyroid disturbance

Calcium excretion is decreased by thiazides Pathologic changes in the parathyroi gland with hypercalcemia and hypophosphatemia have been observed in a few patient on prolonged thiazide therapy The common complications of hyperparathyroidism, suc as renal lithiasis, bone resorption, and peptic ulceration, have not been seen Thiazide should be discontinued before carrying out tests for parathyroid function

DRUG INTERACTIONS. Thiazide drugs may increase the responsiveness t tubocurarine

The antihypertensive effects of thiazides may be enhanced in the postsympathectom patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use

PREGNANCY· Pregnancy Category C. Thiazides cross the placental barrier and appea in cord blood The use of thiazides in pregnancy requires that the anticipated benefit b weighed against possible hazards to the fetus These hazards include fetal or neonata jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred the adult

NURSING MOTHERS· Thiazides appear in human milk. If use of the drug is deeme essential, the patient should stop nursing

PEDIATRIC USE: Safety and effectiveness in children have not been established

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL® LA): Most adverse effects have been mil and transient and have rarely required the withdrawal of therapy

Cardiovascular Bradycardia, congestive heart failure, intensification of AV block, hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually c the Raynaud type

Central Nervous System· Lightheadedness; mental depression manifested by insomnia lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss; emotional lability; slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal· Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea constipation; mesenteric arterial thrombosis; ischemic colitis

Allergic Pharyngitis and agranulocytosis; erythematous rash; fever combined with aching and sore throat, laryngospasm and respiratory distress

Respiratory· Bronchospasm.

Hematologic. Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune. In extremely rare instances, systemic lupus erythematosus has been reported

Miscellaneous Alopecia, LE-like reactions, psoriasiform rashes; dry eyes; male impotence, and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol

Hydrochlorothiazide:
Gastrointestinal: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation; jaundice (intrahepatic cholestatic jaundice); pancreatitis, sialadenitis.

Central Nervous System Dizziness, vertigo, paresthesias; headache; xanthopsia

Hematologic. Leukopenia, agranulocytosis; thrombocytopenia, aplastic anemia

Cardiovascular. Orthostatic hypotension (may be aggravated by alcohol, barbiturates or narcotics)

Hypersensitivity Purpura, photosensitivity; rash; urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis), fever, respiratory distress, including pneumonitis; anaphylactic reactions

Other. Hyperglycemia; glycosuria, hyperuricemia, muscle spasm; weakness, restlessness, transient blurred vision

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

* The appearance of these capsules is a registered trademark of Ayerst Laboratories

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REFERENCE:

1. Ravid M, Lang R, Jutrin I The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily *Arch Intern Med* 1985,145 1321–1323

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By Robert E. Paxton, MD, and
Frank B. Walker, MD

What has the AMA done for me lately?

Paxton

Walker

As physicians outline their budgets for 1987, they e not surprised to see that sts continue to climb. mong their expenses are dues lls for membership in their ofessional organizations — unty, state, specialty socie- es, and the AMA — and the tal figure is significant. Be- use physicians typically have ore frequent contact with eir local medical societies, it sometimes harder for them feel "in touch" with their tional association — the MA. Physicians frequently k, "What has the AMA done r me lately?" Simply stated, e answer is, "Plenty!" But e question deserves an in- pth answer, and this article presents an effort to provide at answer.

AMA membership provides th tangible and intangible nefits. Chief among them is representation of the medical profession. The importance of this activity is reflected in the AMA budget — in 1985, 28 percent of the association's budget was allocated to its primary mission, representation. This activity is so broad in scope that it deserves some attention to the specifics.

Federal-level contacts

Last year, the AMA engaged in over 1,200 Congressional visits, 260 White House contacts, and 1,700 contacts with federal agencies. These contacts represented physicians in the areas of professional liability, attempts to limit physicians' fees, mandatory Medicare assignment, and extension of DRGs to physician services, among myriad others.

Hundreds of bills on health-related issues are introduced into Congress each year. The AMA Council on Legislation, assisted by AMA staff, reviews each of these as well as other proposed legislation. The AMA then formulates a position and engages in the appropriate follow-up which may include making legislative contacts, coordinating member activities for pro or con action, providing verbal or written testimony, and lobbying.

In a related note, AMA lobbyists are among the most highly respected in Washington. Sometimes months before a bill is put together, congressional committee members or their staffs will contact AMA's lobbyists on an issue under consideration to find out the AMA's viewpoint. Legislators also frequently ask AMA lobbyists how the physicians back home feel about a certain issue, and the AMA Washington office maintains a non-negotiable policy of candor in this sensitive area. John Zapp, the Director of the Washington office, says on this subject: "We let the member of Congress know not only the AMA's position but also the sentiment in his or her district, where the physicians may be evenly divided or perhaps even opposed to the AMA position. That's why it's so important for us to work closely with the state medical associations and keep up with what's happening there."

The AMA's Office of the General Counsel engages in a

Continued on next page

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ctor Paxton is chairman, MSMS ard of Directors and Doctor alker is chairman, MSMS delega- n to the AMA.

different kind of advocacy on behalf of physicians — litigation. Examples of AMA legal actions include a suit against the Secretary of HHS to block implementation of the Medicare fee freeze; an *amicus* brief in the US Supreme Court in an antitrust action in which the AMA urges full recognition by the Court of the importance and procompetitive nature of professional ethics and quality of care self-regulation; pursuit in a Federal Court of Appeals and in the US Supreme Court, AMA's opposition to intrusive federal intervention in the treatment decisions regarding severely impaired infants (the *Baby Doe* litigation); a suit filed with the Massachusetts Medical Society challenging the recently enacted Massachusetts law which, in effect, mandates assignment under Medicare as a condition of licensure; active defense of three antitrust suits filed by groups of chiropractors which challenge AMA's support of the ethical principle that physicians should refer patients only to competent medical practitioners who employ scientifically accepted methods of treatment; and so on. AMA may not win all its battles but there are more victories than losses, and in any case, they keep fighting when the issue warrants it.

AMA President John J. Coury, MD, Port Huron general surgeon, is the fifth Michigan physician to lead the nation's doctors.

Professional liability strides

On another front, the AMA has made the professional liability crisis a top priority — a position we understand all too well here in Michigan. The association created a Special Task Force on Professional Liability and Insurance which outlined 18 initiatives in four areas of concern—education and community action, legislation and judicial reform, defense coordination for physicians and their attorneys, and risk control and quality review. Many of these recommendations have already been implemented. For example, the Task Force: prepared and distributed throughout the country a detailed response to allegations of the Association of Trial Lawyers of America that "there is no medical malpractice crisis"; commissioned studies to accurately document the cost to society of the professional liability crisis as well as the savings from tort reform; established a permanent coordination mechanism with the major specialty societies to build a unified assault on the problem; and established a toll-free number at AMA to answer professional liability questions from physicians and their attorneys. Of course, the crowning achievement this past year in this area was the introduction in Congress of federal legislation drafted by the AMA to obtain prompt state action on tort reform.

These efforts will continue through 1986 and beyond unt physicians can provide quality medical care without fear of undue liability exposure. The Task Force has established as major activity for 1986, an examination of alternatives to the tort system for resolution of professional liability claims.

All this activity in the area of representation doesn't mea that the scientific side of the medical profession is neglecte — far from it. The AMA also allocates 26 percent of its budget to providing scientific information, and another eigh percent of maintaining educational standards for physicians.

Through its Diagnostic and Therapeutic Technology Assessment (DATTA) project, the AMA studies new medical technologies and procedures to determine their effectiveness and suitability o clinical uses. These evaluation are conducted by panels of physicians expert in their field and offer indispensable guidance for medical researchers, practicing physicians and national health policymakers.

The AMA Council on Scientific Affairs advises the association, the profession, government, and other health organizations on various aspects of medical science. Among its activities, the Council evaluates and propose scientific initiatives that might be undertaken by the AMA unilaterally or with other organization, and presents its findings to the AMA House of Delegates for further action.

Information source

The AMA also disseminates scientific and health-related information to both the profession and the public. Scientific information is provided to physicians via *JAMA* — which en-

ys international prestige and
now published in seven lan-
uages; nine specialty journals;
id the AMA library — which
the second largest medical
rary in the US and maintains
-line access to more than
00 computerized data bases.
MA also publishes *AM News*,
weekly newspaper reporting
the socioeconomic events
fecting medicine, and numer-
is booklets and references on
ientific and socioeconomic
ibjects.

To help physicians help their
atients, AMA publishes
ooks, pamphlets and posters
n a wide variety of subjects.
atient Medication Instruction
MI) sheets are also available
r physicians to give to pa-
ents to reduce the risk of im-
oper drug use and to aid in
atient compliance. The AMA
so publishes a seven-volume
ome Health Library, which in-
udes such books as *Back*
are, *Heart Care* and *Woman*
are.

ngible benefits and savings

These last few points have
oved into the area of tangi-
e benefits of AMA member-
ip. According to a summary
these benefits developed by
MA, an AMA member can
ve hundreds of dollars over
e cost to a nonmember who
kes advantage of the follow-
g benefits — some of which
e provided free of charge as
automatic benefit of mem-
ership: *JAMA*; one specialty
urnal; *American Medical*
ews; purchase of the book,
Current Procedural Terminol-
gy" (CPT); one Video Clinic
urse; one Market Area Pro-
e (MAP) — a recently deve-
ped service which provides
etailed demographic, physi-
an and hospital data on a
ecific location to assist the
ysician in selecting a prac-
e site or adapting an exist-
g practice to changing
onditions; one AMA Library
mputerized document
arch; use of the AMA Place-
ent Service; enrollment in
e practice management
workshop; rental of one practice management videocassette; one Physician Recognition Award, and use of a Hertz rental car. This doesn't even include the savings to members who enroll in any of the AMA-sponsored insurance programs of the AMA Members Retirement Plan.

Members of the Michigan delegation to the AMA who attended Doctor Coury's installation as AMA president are: (front row from left) Robert E. Paxton, MD; Carl A. Gagliardi, MD; Rhoda M. Powsner, MD; R. Jack Chase, MD; James H. Tisdel, MD; Frank B. Walker, MD; Richard J. McMurray, MD; Amy Gaunt; Robert D. Burton, MD; Gerald H. Mandell, MD; Robert D. Allaben, MD; Robert W. Black, MD; and Donald K. Crandall, MD; (second row from left) Richard H. Gascoigne, MD; Peter A. Duhamel, MD; Busharat Ahmad, MD; Thomas C. Payne, MD; Richard L. Rapport, MD; Kenneth L. Krabbenhoft, MD; Laurie G. McKeown; Louis R. Zako, MD; (back row from left) E. James Potchen, MD; Eric L. Shampaine; William B. Jensen, MD; Billy B. Baumann, MD; Jay K. Harness, MD, and James J. Humes, MD.

From a purely financial perspective, AMA membership is a good deal. For slightly more than a dollar a day, you receive a vast array of benefits and services. In fact, the AMA's advertising and investment income enables it to provide members $2 in service for every $1 in dues (dues make up less than half of the AMA's annual budget). No physician could buy such valuable assistance or influence at so little cost through any other means.

More than a good deal

But the fact is that looking at AMA membership from a financial perspective alone is foolish. It's impossible to put a price tag on the only national organization that speaks for the medical profession as a whole. What is it worth to have a forum of medicine in which physicians raise and argue issues, reach a consensus and formulate policy? What is it worth to have that policy translated into practical action in Congress, in the courts, and in helping patients lead healthier lives?

That is not to say that the AMA is perfect. Like any organization, it has its weaknesses. But can you name one other national organization that works for physicians in so many areas, on such a broad scale, and does it so effectively? There isn't any that even comes close.

"What has the AMA done for me?" It's out there working for you. It's a staff in Chicago and in Washington. But, most important, it's your organization. It's doctors working for doctors — and their patients. ☐

By Shirley Prus

Urge your spouse to join the MSMS Auxiliary

Prust

One of the main efforts this year of the MSMS Auxiliary is to increase membership. I am writing on that subject in a journal read by *physicians* to inform them of the many opportunities available to their *spouses* through Auxiliary.

We have 2,400 members representing 24 counties and members at large. Many counties are not represented, and the ones that are do not include in their membership all of the physician spouses out there. I outline here some of the advantages of MSMS/A membership and enlist your aid in encouraging your spouse to join. (If no Auxiliary group exists in your area, ask your spouse to call me and I'll provide information on how to start one.)

Advantages to belonging to the Michigan State Medical Society Auxiliary range from the personal level to the community level. On the personal side, a major plus is the wonderful friendships that can be developed with members from our state as well as from neighboring ones. Auxiliary is a common bond that we share It enables us to help one another in good *and* bad times. And, exposure to committee processes, the education resulting from participating in and conducting meetings, and awareness of how our local and state societ works, are all constructive self improvements.

Community projects

On the local level all sorts o community activities are available: Meals on Wheels, visiting the elderly, health projects, and public education regarding medicine's views are just a few. This year, an election year, we are especially active in 'getting out the vote' for individuals friendly to medicine.

By belonging to the Auxiliary Federation (county, state and national levels) spouses are provided with valuable information concerning changes in medicine, support programs fo physicians and their families, statewide programs for health care, and legislative issues.

I hope this brief summary will stimulate physicians to encourage their spouses to join MSMS/A. We are anxious to meet them, and to incorporate their talents into our activities.

To remain viable, membership is vital to any organization. Auxiliary membership is a privilege only physicians' spouses have. ☐

Mrs. Prust, of Franklin, is MSMS/A president.

Mutual Memo

3

Risk-reducing records

Third in a series

TO: **Michigan physicians**

FROM: **Loss Prevention, Underwriting and Claims departments**

RE: **Increasing patient satisfaction; preventing claims**

Research on more than 6,500 MPMLC claims shows that comprehensive, accurate medical records are one of the keys to high-quality patient care and low-risk medicine.

Here are four reminders to help you minimize risk through medical record-keeping:

Document all medical treatments.

Clear, complete records enable you and other health professionals to diagnose and care for your patients. Good records are one of the keys to good care.

Sign all entries.

Initial and date all notes you make in a patient's chart to show the treatment you provided chronologically.

Document all telephone calls.

Write down instructions, orders and prescriptions you give over the phone — in the office and at home. Keep a notepad and pen close by for documenting calls. Your office personnel also should note their phone conversations with patients.

Acknowledge all diagnostic reports.

Confirm your review of diagnostic reports by initialing and dating them before filing in the patient record.

Remember, clear and complete medical records can make a difference in patient care, and between winning and losing a liability claim.

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By Herbert A. Au

Here are 20 years of medical society highlights

Another milestone has been reached this year by the Michigan State Medical Society — it's 120th anniversary.

And the next five years will go quickly before the physicians of Michigan observe the 125th anniversary on June 5, 1991.

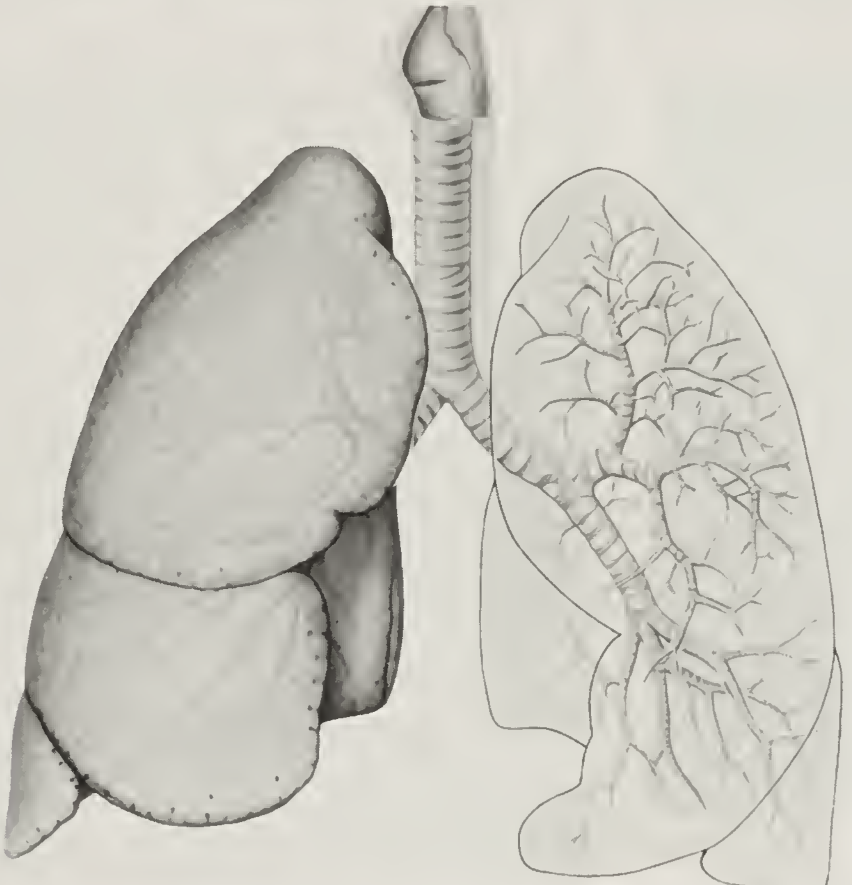
There have been many memorable accomplishments by which MSMS has served the public and the doctors of medicine since that June day 120 years ago. We'll focus in this article on some of the major steps forward during the past 20 years, the two decades since the MSMS centennial celebration which recognized the accomplishments of the first 100 years.

Many MSMS members will recall many of the following highlights, which were selected by this author at random. Sixteen of the 20 MSMS presidents during this 1966-86 period are active today and they will remember these well . . .

- MSMS has worked in new ways with medical students, residents, and hospital staffs to increase communications, services and cooperation.
- MSMS completed the Stockwell Building, named for Cyrus Stockwell, MD, of Port Huron, the first MSMS president.
- *Michigan Medicine* focuses on socioeconomics, dropping scientific articles.
- MSMS communicates each week with its members through *Medigram*.
- MSMS has had expended major effort twice — 11 years ago and again this year — to help resolve some of the professional liability problems.
- MSMS organized the Michigan Physicians Mutual Liability Company to provide liability insurance for MDs and DOs.
- MSMS has developed MDPAC into an effective force for better government.
- Warren Tryloff retired as chief executive. Bruce Ambrose was named executive director and William Madigan, managing director.
- MSMS successfully supported John J. Coury, MD, for several terms as an AMA trustee. He recently became the AMA president.
- MSMS provides through Physician Service Group, Inc. contracted services for specialty societies and other medical/health groups.
- MSMS closed its Detroit office.
- MSMS accredits hospitals specialty societies, etc., to provide Category I CME credit and changed the format of its Annual Scientific Meeting.
- MSMS has year-round, on going relationship with state legislators, with doctors regularly coming to Lansing. Component society meetings frequently feature local legislators.
- MSMS has developed a considerable pool of socioeconomic information and abi ity to do research and to advise and counsel.
- MSMS has increased its consultation with state agencies as they develop rules and regulations.
- MSMS membership has in creased from 7,296 members to 11,006 during the past 20 years.□

Mr. Auer, Traverse City, is former MSMS deputy director and former editor of *Michigan Medicine*.

Consider the causative organisms...



Ceclor®
cefaclor

250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
(ampicillin-susceptible) (ampicillin-resistant)

iel Summary Consult the package literature for prescribing
iformation

ndications and Usage Ceclor® (cefaclor, Lilly) is indicated in the
eatment of the following infections when caused by susceptible
trains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by
*treptococcus pneumoniae (Diplococcus pneumoniae), Haemoph
us influenzae* and *S pyogenes* (group A beta-hemolytic
treptococci)

Appropriate culture and susceptibility studies should be
erformed to determine susceptibility of the causative organism
Ceclor

ontraindication Ceclor is contraindicated in patients with known
llergy to the cephalosporin group of antibiotics

Varnings IN PENICILLIN SENSITIVE PATIENTS, CEPHALO-
PORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY
HERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL
ROSS-ALLERGENICITY OF THE PENICILLINS AND THE
EPHALOSPORINS AND THERE ARE INSTANCES IN WHICH
ATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS,
D BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously
any patient who has demonstrated some form of allergy
articularly to drugs

Pseudomembranous colitis has been reported with virtually all
road-spectrum antibiotics (including macrolides, semisynthetic
enicillins, and cephalosporins), therefore it is important to
onsider its diagnosis in patients who develop diarrhea in
ssociation with the use of antibiotics Such colitis may range in
everity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal
lora of the colon and may permit overgrowth of clostridia Studies
ndicate that a toxin produced by *Clostridium difficile* is one
rimary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to
rug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy appropriate bacteriologic studies and fluid, electrolyte and protein supplementation When the colitis does not improve after the drug has been discontinued or when it is severe oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile* Other causes of colitis should be ruled out

Precautions *General Precautions* – If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued and, if necessary the patient should be treated with appropriate agents e g pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy – Pregnancy Category B – Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor® (cefaclor, Lilly) There are, however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers – Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0 18 0 20 0 21, and 0 16 mcg/ml at two three, four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children – Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain – Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology they are listed below to serve as alerting information for the physician

Hepatic – Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic – Transient fluctuations in leukocyte count predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal – Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

(061782R)

Note Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

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*Additional information available to
the profession on request from
Eli Lilly and Company
Indianapolis Indiana 46285*

Eli Lilly Industries, Inc
Carolina Puerto Rico 00630

MSMS holds liability forums

TATE MEDICAL
CIETY

MSMS leaders took liability reform efforts on the road this summer, holding forums in four areas of the state. Above, MSMS Board Chairman Robert Paxton, MD, fields a question.

Louis Heideman, MD, Birmingham, left, and Lawrence L. MacDonald, medical student, right, were among the attendees.

MR. WEBER
DR. GAGLIARD

Richard Weber, MSMS legal counsel, left, and Carl A. Gagliardi, MD, MSMS president-elect, detailed further MSMS plans toward liability reform: to publicly state that there is much yet to be done; to pursue lower insurance rates; to pursue alternative coverage for high risk MDs; to continue legislative contact; to support limiting contingency fees; to pursue binding arbitration.

Louis R. Zako, MD, Birmingham, is chairman of the MSMS Task Force on Liability Reform. He spoke passionately in support of further reform efforts.

CONFIRMED

CONFIRMED BY CLINICAL EVIDENCE

ZANTAC® 150 h.s.

ranitidine HCl/Glaxo 150 mg tablets

EFFECTIVE MAINTENANCE THERAPY

for healed duodenal ulcer patients

CONFIRMED

In two randomized, double-blind, and well-controlled clinical trials, ZANTAC 150 mg h.s. significantly superior to cimetidine 400 mg h.s. for maintenance therapy in healed duodenal ulcers.

Percent of patients with observed duodenal ulcer recurrence

		0-4 months	0-8 months	0-12 months	No. patients
USA[1]	ranitidine 150 mg h.s.	9%	14%*	16%†	60
	cimetidine 400 mg h.s.	23%	34%	43%	66
UK, Ireland, Australia[2]	ranitidine 150 mg h.s.	8%‡	14%‡	23%‡	243
	cimetidine 400 mg h.s.	21%	34%	37%	241

*$p=0.02$
†$p=0.01$
‡$p \leq 0.004$
%=life-table estimates
All patients were permitted prn antacids for relief of pain.

These two trials used the currently recommended dosing regimen of cimetidine (400 mg h.s.) and ranitidine (150 mg h.s.). A comparison of other dosing regimens has not been studied.

The studied dosing regimens are not equivalent with respect to the degree and duration of acid suppression or suppression of nocturnal acid.

The superiority of ranitidine over cimetidine in these trials indicates that the dosing regimen currently recommended for cimetidine is less likely to be as successful in maintenance therapy.

Convenient once-a-night dose with a low incidence of side effects[3]

Headache, sometimes severe, seems to be related to ranitidine administration. Other side effects have been reported; for a complete listing, see the ADVERSE REACTIONS section in the Brief Summary.

No significant interference with the hepatic cytochrome P-450 enzyme system at recommended doses

ZANTAC 150 mg has no significant drug interactions with theophylline, phenytoin, or warfarin. The bioavailability of certain medications whose absorption is dependent on a low gastric pH may be altered when ZANTAC or other medications that decrease gastric acidity are administered.

Zantac® 150

ranitidine HCl/Glaxo 150 mg tablets

One tablet at bedtime
for maintenance

See next page for references and
Brief Summary of Product Information.

Glaxo/ROCHE®

CONFIRMED

Zantac® 150

ranitidine HCl/Glaxo 150 mg tablets

One tablet at bedtime for maintenance therapy in healed duodenal ulcer patients

References:

1 Silvis SE, Griffin J, Hardin R, et al: Final report on the United States multicenter trial comparing ranitidine to cimetidine as maintenance therapy following healing of duodenal ulcer. *J Clin Gastroenterol* 1985;7(6):482-487.

2. Gough KR, Korman MG, Bardhan KD, et al: Ranitidine and cimetidine in prevention of duodenal ulcer relapse· A double-blind, randomised, multicentre, comparative trial. *Lancet* 1984;ii 659-662.

3. Data available on request, Glaxo Inc.

ZANTAC® 150 Tablets
(ranitidine hydrochloride)
ZANTAC® 300 Tablets
(ranitidine hydrochloride)

BRIEF SUMMARY OF PRODUCT INFORMATION

See complete product information before prescribing. The following is a brief summary.

INDICATIONS AND USAGE: ZANTAC® is indicated in:

1. Short term treatment of **active duodenal ulcer** Most patients heal within four weeks.

2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.

3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).

4 Short-term treatment of **active, benign gastric ulcer** Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.

5 Treatment of **gastroesophageal reflux disease (GERD)**. Symptomatic relief commonly occurs within one or two weeks after starting therapy Therapy for longer than six weeks has not been studied.

In active duodenal ulcer, active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: ZANTAC® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: General: 1 Symptomatic response to ZANTAC® therapy does not preclude the presence of gastric malignancy 2. Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function. Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during ZANTAC therapy, and therefore testing with sulfosalicylic acid is recommended

Drug Interactions: Although ZANTAC has been reported to bind weakly to cytochrome P-450 in vitro, recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH dependent effect on absorption or a change in volume of distribution).

Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at doses up to 2,000 mg/kg/day.

Ranitidine was not mutagenic in standard bacterial tests *(Salmonella, E coli)* for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next nine weeks.

Pregnancy: ***Teratogenic Effects: Pregnancy Category B:*** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ZANTAC. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: ZANTAC is secreted in human milk. Caution should be exercised when ZANTAC is administered to a nursing mother

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age groups

ADVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with oral ZANTAC®. The relationship to ZANTAC therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to ZANTAC administration.

Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients.

Cardiovascular: Rare reports of tachycardia, bradycardia, and premature ventricular beats.

Gastrointestinal. Constipation, diarrhea, nausea/vomiting, and abdominal discomfort/pain.

Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid IV for seven days, and in 4 of 24 subjects receiving 50 mg qid IV for five days. With oral administration there have been occasional reports of reversible hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice.

Musculoskeletal: Rare reports of arthralgias.

Hematologic: Rare reports of reversible leukopenia, granulocytopenia, thrombocytopenia, and pancytopenia.

Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by ZANTAC and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when ZANTAC has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving ZANTAC, but the incidence did not differ from that in the general population.

Integumental: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia

Other: Rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia) and small increases in serum creatinine.

DOSAGE AND ADMINISTRATION: Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg twice daily. An alternate dosage of 300 mg once daily at bedtime can be used for patients in whom dosing convenience is important The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison Syndrome): The current recommended adult oral dosage is 150 mg twice a day In some patients it may be necessary to administer ZANTAC® 150 mg doses more frequently. Doses should be adjusted to individual patient needs, and should continue as long as clinically indicated. Doses up to 6 g/day have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg twice a day

GERD: The current recommended adult oral dosage is 150 mg twice a day.

See full prescribing information for dosage adjustment for patients with impaired renal function.

HOW SUPPLIED: ZANTAC® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) and unit dose packs of 100 tablets (NDC 0173-0393-47).

ZANTAC® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 tablets (NDC 0173-0344-42) and unit dose packs of 100 tablets (NDC 0173-0344-47).

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

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By Elmer White

Health Education FOUNDATION: setting new goals

You might ask, ''What is the Health Education Foun-lation?''

It's a good question. The an-wer describes a new effort, upported by MSMS, to deal vith current health problems in ur society and improving the vay people live. Goals are pecified in the Foundation's iew mission statement which ippears on this page.

John R. Ylvisaker, MD, loomfield Hills, a former resident of MSMS, was lected president of the Foun-lation in 1983, and has led in stablishing new goals and ex-anding directions of the Foun-lation.

Already underway is a oundation-financed evaluation roject at Oakland University's Meadowbrook Health Enhance-nent Institute. This provides or ongoing evaluation of a hree-year health promotion rogram, and the ability to roduce interim reports hroughout the program. The oundation also is working vith impaired physicians hrough loan funds. Other pro-rams under consideration in he revitalized Foundation ef-orts are aimed to enhance ealth lifestyles of the general ublic.

Health Education Foundation is the new name for the Michigan Foundation for Medical and Health Education, which for many years provided support for worthy students in Michigan's medical colleges. The new name was selected to imply the expanded and more vigorous scope of the Foundation.

The original Foundation was organized September 19, 1945. Earl J. Carr, MD, Lansing, was its first president and he served in that capacity until 1969. James D. Bruce, MD, Ann Arbor, was one of the original and important financial supporters. A significant portion of Foundation efforts still is the restricted ''Bruce Fund.''

Harry A. Towsley, MD, Ann Arbor, was elected president in 1969, and held that position until 1983, when succeded by Doctor Ylvisaker.

Now Doctor Ylvisaker is directing the Foundation into new areas to meet the emerging needs of the next decade. The board of trustees has been expanded to gain added breadth and scope of interests and expertise.

As president of the Health Education Foundation, Doctor

Continued on page 560

Mr. White is a member of the oard of directors, Health Educa-ion Foundation, and is former ex-ecutive director of the Michigan ress Association.

Mission statement: Health Education Foundation

The Health Education Foundation is a non-profit charitable corporation sponsored by the Michigan State Medical Society. The purpose of the Foundation is to advance the field of health for the public good. The mission of the Foundation is to achieve the following:

- Stimulate, support, and/or initiate lay or professional education, research programs, and projects in the field of health.
- Encourage the advancement of healthy lifestyles, the prevention, diagnosis, or cure of disease, and the care of the sick and the dying.
- Provide a vehicle for the Michigan State Medical Society to foster humanitarian public service in health education and research, and to provide support for physicians who suffer impairment.
- Develop and administer funds for the support of health education and research.
- Provide a resource for the management and distribution of signature funds or bequests designated for special health education and research purposes.

PLEASE SEND ENTIRE PAGE WITH CHECK

1986 MSMS Annual Scientific Meeting, Hyatt Regency Dearb
Registration form for Category I CME Courses

*All courses are approved for AAFP Prescribed Credit EXCEPT those marked with an asterisk.

TUESDAY MORNING, NOV. 11
(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Adult Respiratory Distress Syndrome
____ Approach to Neurologic Emergencies for the General Physician
____ Basic Cardiac Life Support
____ Congenital Heart Disease: An Update
*____ Current Management of Colorectal Malignancies
____ Pediatric Infectious Diseases (Alpha-Omega Part I)
____ Rediscovered Epidemics in the Work Place
____ The Multimodality Treatment of Breast Cancer
____ Therapy of Acute and Chronic Intoxication

TUESDAY AFTERNOON, NOV. 11
(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Bioethics: From Here to Eternity (Part I)
____ Critical Care Procedures for Primary Care Physicians
____ Evaluation & Management of the Confused Elderly Patient
____ Osteoporosis 1986: A Silent Epidemic
*____ Perioperative Management of the High-Risk Surgical Patient
____ Somatization Syndrome
*____ What's New in Surgical Oncology

WEDNESDAY MORNING, NOV. 12
(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Basic Cardiac Life Support
____ Blood: Its Use and Abuse
____ Controversies in Management of Acute Myocardial Infarction
____ Diabetes — A Current Clinical Overview
____ Genitourinary Infections (Alpha-Omega Part 2)
*____ Peripheral Nerve Injuries
____ Principles of Psychotherapy
____ Recognizing and Understanding Toxic Substance Exposures
____ Sexual Dysfunction Secondary to Cancer and Cancer Treatment
____ Sports Injuries in Primary Care

WEDNESDAY AFTERNOON, NOV. 12
(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Bioethics: From Here to Eternity (Part 2)
____ Clinical Applications of Magnetic Resonance Imaging: Update
____ Infectious Diseases of the Head & Neck
____ Keeping Current in Office Gynecology
____ New Directions & Controversies in Treatment of Cancer of the Breast & Prostate
*____ New Techniques in Genetics for Prenatal Diagnosis
____ Optimal Management of the Thyroid Patient
____ Sexual Myths and Perversions
____ Update in Immunology/Allergy
____ What's New in Dermatology

THURSDAY MORNING, NOV. 13
(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Basic Cardiac Life Support
____ Common Pediatric Surgical Problems
*____ Cosmetic Surgery
____ Gait-Way to Successful Diagnosis
____ Infectious Diseases in the Elderly and Immunocompromised Patient (Alpha-Omega Part 3)
____ Non-Articular Rheumatism
____ Nutrition and Exercise
____ Role of Nutrients in Blood Pressure Control
____ The Silent Danger: Recognizing and Managing Closed Head Injury

THURSDAY AFTERNOON, NOV. 13
(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

*____ Advances in Plastic & Reconstructive Surgery — 1986
____ AIDS Update
____ Bioethics: From Here to Eternity (Part 3)
____ Carcinoma of the Breast
____ Common Anorectal Problems
____ Essentials of Acid Base and Fluid and Electrolyte Disorders
____ Food Poisonings, Carbon Monoxide Intoxication and Anaphylaxis
*____ Peripheral Vascular Diseases
____ Quality Control for the Office Laboratory

The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation, designates this activity meets the criteria for a maximum of 18 credit hours in Category I toward the requirements for Michigan relicensure and of the Physician Recognition Award of the AMA, provided it is completed as designed.

Please check the courses you wish to attend. In each case, *please indicate a second choice* should the first choice already be filled. Maximum attendance figures have been set for each course, depending on room size.

Send this entire page with your check. Confirmation of your reservation will be sent to you. Your course credentials, badge, and luncheon tickets must be picked up at the MSMS Registration Desk in the Great Lakes Exhibit Center.

Physicians must make their own hotel reservations prior to 10/17/86 direct with the Hyatt Regency Dearborn, Fairlane Town Center, Dearborn, MI 48126, 313/593-1234. In order to take advantage of the special conference rates, please mention that you will be attending the MSMS Annual Scientific Meeting.

See room reservation card for details about how you can win a complimentary room and dinner for two at Giulio's by making your room reservations early!

Name ____________________
(please print) (first) (initial) (last)

Street ____________________

City, State ______________ Zip ______________ Phone ______________

MSMS Member: Yes ☐ No ☐ Resident ☐ Specialty______________Other ______________

Tuition Schedule for Courses:

MSMS Members: $25 for each half-day course
MSMS Members with "retired status" pay half the regular course fee
Non-members: $50 for each half-day course
Residents: $10 PER COURSE
Students: NO CHARGE — Limited Enrollment (lunch tickets may be purchased at Registration Desk)

A deli sandwich lunch will be provided at no extra charge for paid registrants. Advance notice is requeste so MSMS can give an accurate guarantee. Please indicate which days you want a lunch ticket.

- Tuesday lunch ☐ Wednesday lunch ☐ Thursday lunch ☐

- Indicate total number of half-day courses:

____ x $25 (members) $ ______
____ x $12 (retired) $ ______
____ x $50 (non-members) $ ______
____ x $10 (residents) $ ______
TOTAL $ ______

Make checks payable to MSMS and mail to MSMS, Box 950, East Lansing, MI 48823

ANNOUNCING

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Monday, February 3 through Friday, February 6, 1987

STATE OF THE ART IN MEDICINE AND SURGERY

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Conference Chairman: Ralph Blocksma, M.D.
Conference Coordinator: Celia M. Steele
Phone: (616) 774-1835

A Partial Listing of the Faculty Includes:

Ian T. Jackson, M.D., Mayo Clinic
Glenn W. Geelhoed, M.D., Washington, D.C.
Evelyn J. Fisher, M.D., Henry Ford Hospital
Donald Grell, M.D., University of the West Indies, Jamaica
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Benjamin Spock, M.D., U.S. Virgin Islands
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John S. Kirkham, FRCS, London, England
Peter R. Riddle, FRCS, London, England
Kenneth L. Standard, M.D., University of the West Indies, Jamaica
Donald A. Scholz, M.D., Mayo Clinic
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Richard G. Van Dellen, M.D., Mayo Clinic
Christian VandenBerg, M.D., Mayo Clinic
Leonard Weyl, M.D., Washington, D.C.
Erle E. Peacock, M.D., Chapel Hill, North Carolina
Joel E. Stevens, M.D., Washington, D.C.

Early Registration is Recommended.
For further information call: Celia M. Steele at (616) 774-1835

By Thomas J. DeKornfeld, M

New Board of Medicine rules ease applicants' assessment

DeKornfeld

On May 10, 1986 new Administrative Rules were promulgated by the Michigan Board of Medicine. These rules were the result of much thought and effort, numerous meetings, including a public hearing, and of a sincere desire to provide the people of Michigan with the most competent physicians that a licensing process can provide.

The motivation for changing the rules was as follows:

1. The US Department of Health and Human Services has found that a number of foreign medical graduates used phony credentials to become licensed, and urged the states to tighten their licensure requirements.

2. The Board became increasingly concerned about the education received by some graduates in some foreign medical schools. The concern was relative to the basic science instruction, but also, and more particularly, to the clinical clerkships. Many of the latter were provided in hospitals which had few, if any, claims to being educationally-oriented health care facilities. In an effort to assure minimal training standards the Board decided that all clinical clerkships had to be completed in hospitals which were at least substantially equivalent to the hospitals accredited by the Joint Commission on Accreditation of Hospitals (JCAH).

Summarized rules

The Rules under which the Board now must operate did go into effect on May 10, 1986. Their most pertinent sections may be summarized as follows: For an unlimited license the applicant shall "establish that he or she had completed the requirements for a degree in medicine" (R 388.2316) in addition to having a valid certificate issued by the Educational Commission for Foreign Medical Graduates, having passed FLEX and having completed three years of postgraduate training in an American Council on Graduate Medical Education approved program in the United States or Canada.

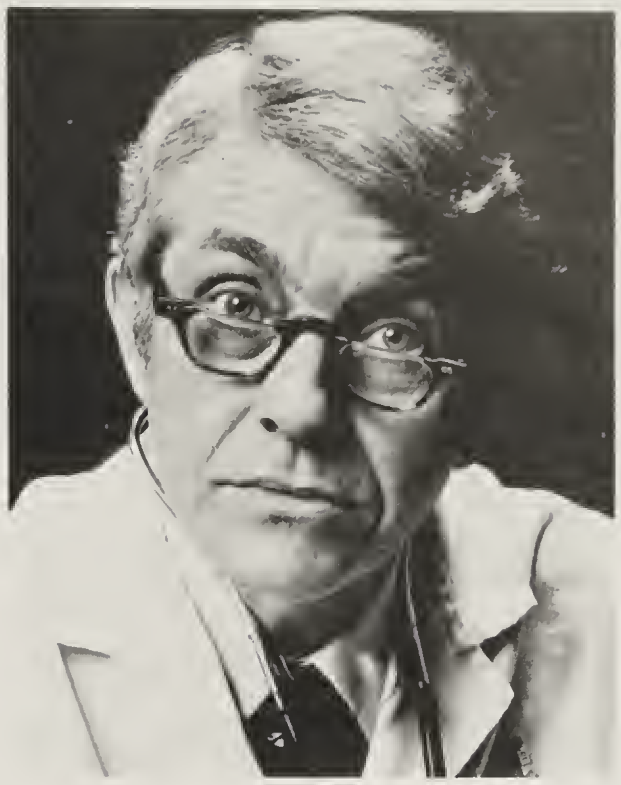
The term "completed the requirements for a degree in medicine" is defined in Administrative Rule R 338.2301(c) as follows:

> "The applicants shall have satisfactorily completed a medical educational program, covering a period equivalent to four academic years. Two of the academic years shall be devoted to a course of study in a basic science curriculum which, at a minimum, shall include anatomy, biochemistry, microbiology, pharmacology and pathology. Two of the academic years shall be devoted to clinical clerkships in, at least, surgery, obstetrics and gynecology, psychiatry, pediatrics and internal medicine. All clerkships shall be completed in a hospital or institution approved by the Board."

The first part of this requirement means that the applicant must provide the Board with a complete transcript of his/her medical school curriculum. If the transcript is in any language other than English, an authorized translation must accompany it. The second part requires that the Board be provided with sufficient infor-

Continued on page 560

Doctor DeKornfeld is administrator of the Michigan Board of Medicine.



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BOARD OF MEDICINE/Continued

mation to determine whether the standards of each hospital where the applicant completed clinical clerkship are substantially equivalent to the standards of the JCAH accredited hospitals. For a hospital to do this, it must either show that it currently holds JCAH accreditation or must complete a questionnaire provided by the Board.

This questionnaire has been designed to make it as easy as possible for the hospital to provide the information required by the Board. To date we have no track record as to the hospitals' willingness or ability to comply. If the hospitals choose to ignore the request for information, the Board will have no choice but to deny the application. The Rules state very clearly that the Board *must* approve the hospitals and if the Board does not have the information that would allow it to do so, it obviously will not be able to grant a license to an applicant who has received training in that institution.

Limited Educational license

The Rules applying to a Limited Educational license will take effect on January 1, 1987. To qualify for this license the applicant must not only establish that he or she has "completed the requirements for a degree in medicine," but also that the requirements were completed in a school approved by the Board. To be able to approve a school, the Board must be satisfied that the school's standards are substantially equivalent to the standards of the Liaison Committee on Medical Education which is the accrediting agency for the medical schools in the United States.

In order for the schools to be able to do this, they will have to provide the Board wi a considerable amount of information. The Board staff ha designed an additional questionnaire, which when completed should allow the Board to make that determination. This questionnaire is very similar to the one used by several other states. Most schools should be able to complete it with relatively moderate effor

In summary, the new Rules were designed with the intere of providing and maintaining minimal standard of health care. There is nothing in the new Rules which will make the licensure of foreign medical graduates impossible or even prohibitively difficult. They do require more information than the old rules, but this information, when provided, will mak it possible to more accurately assess the education and training of the applicant.☐

Board of Medicine action

The following action of the Michigan Board of Medicine was taken following investigative and appropriate action and is reproduced verbatim from a summary prepared by the Michigan Department of Licensing and Regulation.

Name: Edward Jenner Howard, MD

Action, Date Taken: Revoked and Fined $3,000 August 6, 1986.

Reason: Convicted of a crime reasonably related to and adversely affecting his ability to practice medicine in a safe and competent manner.

FOUNDATION/Continued

Ylvisaker encourages MSMS members to support this program, not only to help deal with public health problems, but as a source of satisfaction for the contributor in the knowledge that he or she is helping deal with important and changing health problems in Michigan.

Watch for a letter inviting you to support the Foundation through a tax-deductible contribution.

A broadly based board of directors of both physicians and non-physicians assists Doctor Ylvisaker to administer Foundation programs and develop effective new programs. Members of the board are: Doctor Ylvisaker, president; Doctor Towsley, vice-president; Bruce W. Ambrose, MSMS executive director, vice-president; Robert E. Paxton, MD, Fremont, treasurer; Thomas R. Berglund, MD, Portage; Mark Campbell, MD, Grand Rapids; Nancy Crandall, Muskegon; A. Stewart Kerr, JD Detroit; Richard J. McMurray, MD, Flint; Justin L. Sleight, MD Lansing; Arthur L. Tuuri, MD, Flint; Elmer E. White, East Lansing; and Carl A. Gagliardi, MD, Dearborn, MSMS president elect. Vada L. Davis, manager, MSMS Administratio and Physician Education Department, is the corporate secretary.☐

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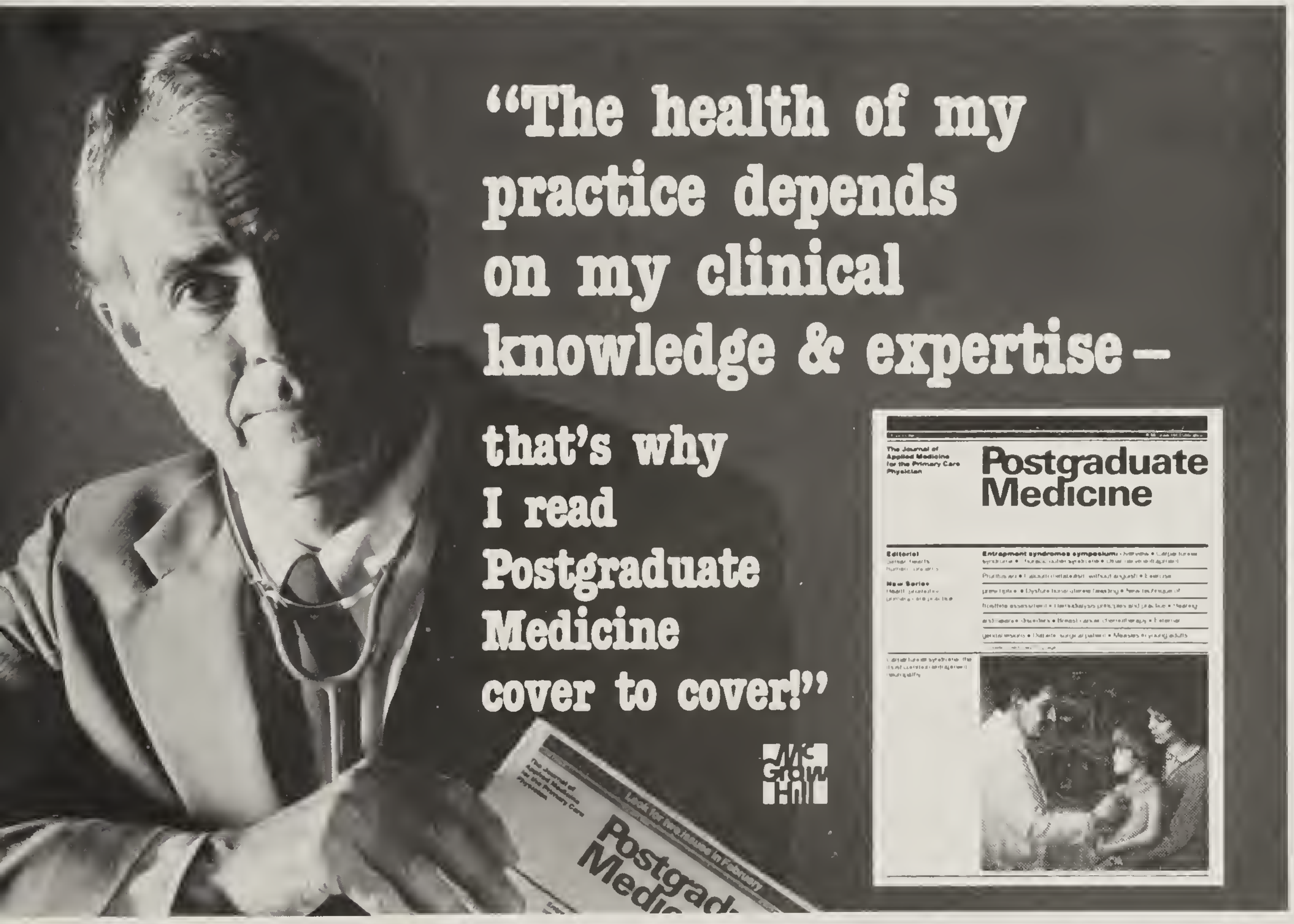
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By Michael Galvin, M

Saving a life brings malpractice to mind

I saved a 7-year old child's life recently.

More exactly, with the help of some very skilled people including an emergency room physician, an anesthesiologist, a lung specialist and a handful of respiratory therapists, laboratory technicians and nurses, I managed to keep the child's asthma from killing her.

She was struggling to breathe. Acid was building up in her blood. Any intern can tell you that a girl whose blood pH is 6.98 and whose pCO2 is 97 is near death. This girl looked it. It was nighttime, and for the next nine hours, I was not be more than 50 feet from her. I catnapped in an empty hospital bed nearby, but for most of the nine hours I was awake and thought of little else but saving her life. It actually took nine hours before she turned the corner and got better. I was then able to go home to a shower and bed.

Her loved ones were grateful. I could see that all the nurses and technicians were quietly proud and happy that they had done their jobs so well.

I ought to be elated.

The girl lived because I managed in time to marshal the right people and the right tools together to save her. It was close, but she lived and has no brain damage. Such life and death situations come rarely for a pediatrician like me. Much of my time is spent with children whose runny noses and diarrhea will get better in a few days no matter what I do. Mainly, I offer parents reassurance.

Sometimes, however, such as that night, I discover a life-threatening illness in time to make a difference. There was a time, in my training five years ago, when I would have been bursting with pride and excitement after such a "save." I would have gone over such a case again and again with my fellow doctors-in-training, reliving the excitement of trying out a new drug and seeing it work, of myself being tested and rising to the challenge. I was gung-ho then. Nervous sometimes, but mainly I thought I was pretty hot stuff.

Today, however, I'm balder, 40 pounds heavier, five years older, more than $20,000 in debt and have one malpractice suit behind me. Actually, I simply feel relieved — relieved that the patient lived. This time I won't be sued.

That night after I had been up with this girl, I couldn't sleep. At 1:30 am, I felt compelled to put my thoughts on paper. I thought maybe that would help put some of the troubling thoughts behind me. The $30 or $40 Medicaid that will, in a few months, pay me for caring for this child will not go far in covering my $8,770 malpractice insurance premium that was due July 7.

I'll need to see 400 patients at $22 each office visit to pay for that. That buys me $200,000 protection. If I make a mistake this year, that will probably cover the costs of my suit. Probably. If I am sued, my insurance will let my family keep our $55,000 house, our two cars, and, if I can get an IRA started this year, we'll probably be able to keep tha too.

Lawyers who are friends of mine tell me I should keep m perspective. All this is just th cost of doing business. I shouldn't take this personally take little comfort in that. Th memory of the little girl that night is too fresh.

Let's imagine a similar theoretical case. Let's assume tha a patient did indeed die. Perhaps the survivors, after dealing with their grief, woul ask themselves why the patie died. After all, it wasn't cancer. It was asthma, from which children almost always get better.

Other family members, relatives or friends, seeing the pa ents' agony, might encourage them to see a lawyer. That lawyer could take months poring over every detail in the hospital record.

He or she might find an error, some inexplicable delay i getting a necessary treatment or test done, some option tha might have worked better. I, myself, can point to things I might do differently next time

A lawyer and his or her consultants in the months ahead might find something to question. I know I could defend my decisions to the satisfaction o my fellow pediatricians, but a good lawyer might find a way to make me look bad to a jury of lay people.

And that's who would judge me in the end.

No lawyer will look over the case of the 7-year old with asthma, though. That was a success story. Decisions made months ago by hospital administrators and nursing supervisors and the skills of nurses, respiratory therapists, lab technicians and four doctors came together that night, and a girl was saved. Indeed, our medica team did some fine work.

I should be feeling good.☐

Doctor Galvin is a Muskegon pediatrician.

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Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: **Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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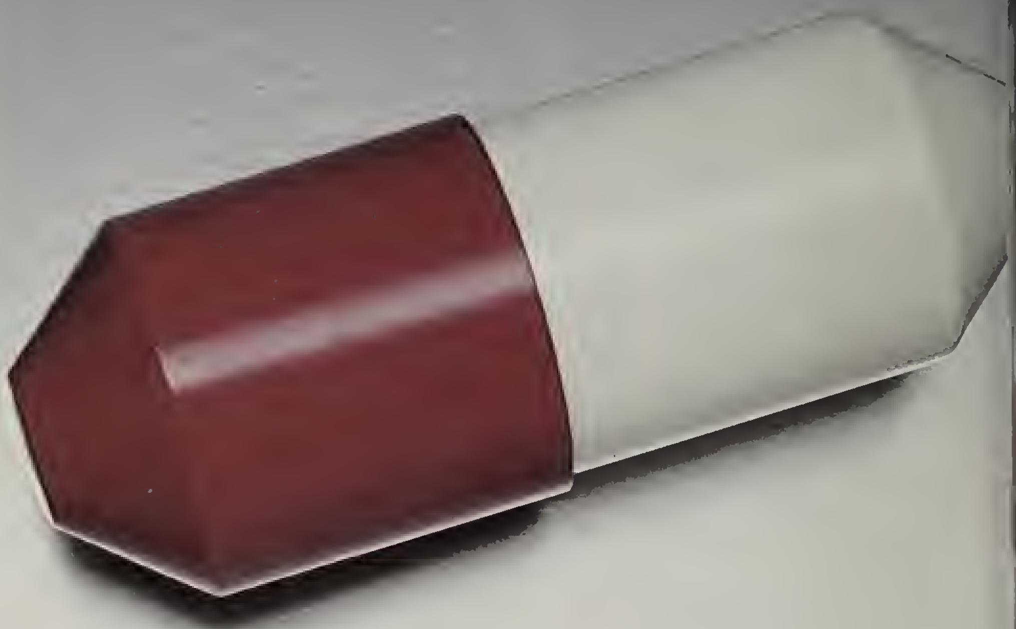

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***See Warnings and Precautions.**

Please see brief summary of prescribing information on the next page.

CARDIZEM® diltiazem HCl/Marion FEW SIDE EFFECTS IN ANTIANGINAL THERAPY

60 mg tid or qid

Brief Summary
Professional Use Information

CARDIZEM®
(diltiazem HCl) 30 mg and 60 mg Tablets

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS

General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women, therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.*
Nervous System.	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal.	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic.	*Petechiae, pruritus, photosensitivity, urticaria.*
Other.	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. *Issued 7/86*

See complete Professional Use Information before prescribing.

References: ***1.*** *Pepine CJ, Feldman RL, Hill JA, et al. Clinical outcome after treatment of rest angina with calcium blockers. Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983, 106(6):1341-1347.* ***2.*** *Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984,24(Dec):150-159.* ***3.*** *Johnston DL, Lesoway R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985,55:680-687.* ***4.*** *Cohn PF, Braunwald E. Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39.* ***5.*** *Schroeder JS. Calcium and beta blockers in ischemic heart disease. When to use which. Mod Med 1982;50(Sept):94-116.*

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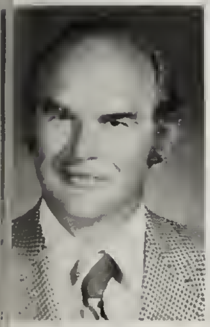
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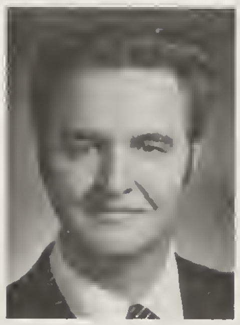
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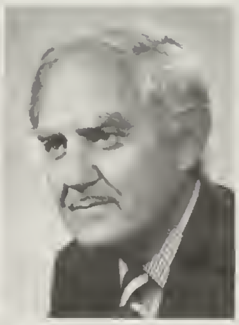
Walt

ichael Kaplan, MD, Detroit, iief of transplant services; **ale Sillix, MD,** Detroit, direc- ır of the transplant program; ıd **Franklin McDonald, MD,** etroit, chief of medicine at utzel Hospital recently spoke the forum on kidney trans- antation presented by Hutzel ospital and Wayne State Uni- ersity. . . . **Marjorie Peebles- ieyers, MD,** Detroit, has been amed to the Michigan /omen's Hall of Fame. Doctor eebles-Meyers was the first lack woman to graduate from /ayne State University's medi- al school. . . . **Charles Oakes, ID,** Harbor Beach, has do- ated his Harbor Beach medi- al facilities, now called the enry Ford Hospital Oakes enter, and a residence to the ospital. The gift will benefit ıe members of the Huron ounty community which he erved for more than 50 ears. . . . **Phillip Howard, MD,** resented a generous gift to ıe Department of Pediatrics at enry Ford Hospital. The gift ill provide funding for the hillip J. Howard Pediatric Lec- ureship. Doctor Howard was ith the Department of Pedi- trics at Henry Ford Hospital or 50 years until his retire- ient in 1977. . . . **John A. upke, MD,** Grand Rapids, has been elected the president of the National Association for Ambulatory Care. . . . **William Heatley, MD,** Waterford, and **William G. Zimmerman, MD,** Grand Rapids, will serve on the Board of Directors of the Flying Physicians Association, Inc. . . . **C. Mark Vasu, MD,** Grand Rapids, has been reappointed to the Michigan Emergency Medical Services Advisory Council. . . . **Alexander J. Walt, MD,** Detroit, professor and chairman, Department of Surgery, Wayne State University School of Medicine, was guest speaker at the Saint John Hospital graduation ceremony. Doctor Walt spoke on "Educating for the 21st Century." . . . **Peter Duhamel, MD,** Rochester, was chosen member at large for the governing council of AMA's Hospital Medical Staff Section. The council is a liaison between AMA governing bodies and the Joint Commission on Accreditation of Hospitals. . . . **Richard P. Horsch, MD,** Livonia, was recently installed as president of the Wayne County Medical Society. Doctor Horsch is an anesthesiologist at St. Mary Hospital in Livonia. . . . **Reed K. Freidinger, MD,** Charlevoix, has been elected to the Board of Directors of the Michigan Peer Review Organization. . . . **Joshua Wynne, MD,** Detroit, has been elected to the board of trustees of the American Heart Association of Michigan. Doctor Wynne is chief of cardiology at Harper Hospital and was elected to a one-year term. . . . **Lynda Biedrzycki, MD,** Royal Oak, has been appointed a deputy medical examiner of Oakland County. . . . **William N. Kelley, MD,** Ann Arbor, has begun a one-year term as president of the American Rheumatism Association. Doctor Kelley is chairman of the Department of Internal Medicine at the University of Michigan Medical School. . . . **Raymond Jackson, MD,** Southfield, has been elected to the board of directors of the Michigan Chapter of the American College of Emergency Physicians. Doctor Jackson is director of research in the department of emergency medicine at William Beaumont Hospital, Royal Oak. . . . **Joseph T. Batdorf, MD,** Grand Blanc, was elected to a two-year term as president of the St. Joseph Hospital medical staff. . . . **George Adler, MD,** Saginaw, recently received a meritorious service award from the Michigan Chapter of the

Continued on page 568

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NEWS/Continued

American College of Emergency Physicians for his excellence in the principles and practice of emergency medicine in Michigan. . . . **Walter F. Hamilton, Jr, MD,** North Lake, has been elected chairman of the board of trustees of Chelsea Community Hospital. . . . **Robert M. Nelson, MD,** Farmington Hills, is the new president of the medical staff at Detroit Receiving Hospital and the University Health Center. Doctor Nelson is assistant professor of surgery and coordinator of the residency program at Wayne State University. . . . **Bernard W. Agranoff, MD,** Ann Arbor, has been awarded the University of Michigan Biomedical Research Council's Distinguished Faculty Lectureship in Biomedical Research for 1986. . . . **Joel I. Hamburger, MD,** Southfield, has been honored by the Department of Surgery of Sinai Hospital of Detroit for the completion of his 25th year of study and practice of clinical thyroidology. A monograph will be published featuring his selected articles containing the more important precepts that have continuing relevance to the practice of clinical thyroidology. . . . **Douglas Greene, MD,** Ann Arbor, has been named director of the Michigan Diabetes Research and Training Center at the University of Michigan Medical Center. . . . **George W. Morley, MD,** Ann Arbor, has been named president-elect of the American College of Obstetricians & Gynecologists. . . . **Paul T. Niland, MD,** East Lansing; **Richard R. Oslund, MD,** North Muskegon; **Michael A. Sandle MD,** West Bloomfield, and **Daniel R. Guyot, MD,** Grosse Ile, have received special recognition from their peers during the convocation ceremonies at the annual mee ing of the American College o Radiology, for their outstanding contributions to the field of radiology. . . . **Richard E. Honicky, MD,** East Lansing, ha been appointed to the Air Pollution Control Commission by Gov. James Blanchard. Doctor Honicky is a pediatric pulmonologist at Ingham Medical Center and an assistant professor at Michigan State University's pediatrics department. . . . **James Bash, MD,** Bark River, was presented with the annual Roche Laboratories award recognizing outstanding family practice residents. . . . **Nathan Levin, MD,** Detroit, has been re-elected vice president of the national Renal Physicians Association. Doctor Levin, also has been elected chairman of the Hemodialyzer Reuse Subcommittee of the Association of Advancement of Medical Instrumentation. . . . **Lionel Finkelstein, MD,** Birmingham, received the Teacher of the Year Award from the psychiatric residents of Sinai Hospital of Detroit. Doctor Finkelstein also is a Councilor, a member of the Program and Public Information Committee, and is on the Committee on Peer Review of the Michigan Psychiatric Society. ☐

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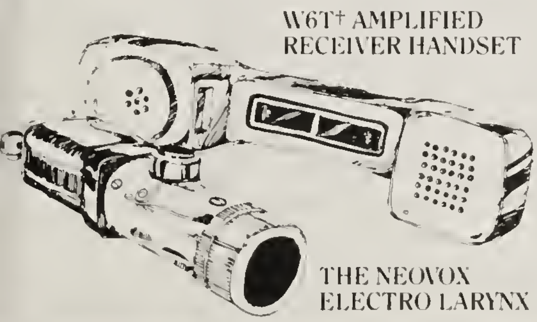

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(313) 223-8732 (Voice/TDD)

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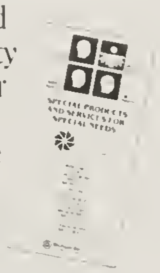

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Arnold A. Albright, MD
Battle Creek

Doctor Albright died June 25 at the age of 83. Doctor Albright received his medical degree from Johns Hopkins University in 1929. He was past president of the Calhoun County Medical Society; a medical adviser to the Michigan legislature and had served as chief of ophthalmology at Community, Leila and the former Battle Creek Sanitarium hospitals. Doctor Albright also was former clinic chief at the old Percy Jones General Hospital. He maintained a private practice in Battle Creek for 19 years before retiring in 1973.

Bass

Vernon Bass, MD
Saginaw

Doctor Bass died September 14 at the age of 69. He received his medical degree in 1950 from the University of Wisconsin Medical School. Doctor Bass was a former MSMS delegate from Saginaw and served as speaker of the MSMS House of Delegates. In 1976 Doctor Bass was elected MSMS president-elect and was installed as president in 1977. He was also instrumental in the formation of the Michigan Physicians Mutual Liability Company (MPMLC) and was elected the first president in 1976 for a two-year term. Doctor Bass was former chairman of MDPAC and had served as chairman of the MPMLC Board of Directors.

Shelby M. Baylis, MD
Clarkston

Doctor Baylis died August 14 at the age of 58. Doctor Baylis was a practicing family physician in Clarkston and was former chairman of the surgery department at Pontiac General Hospital. He was medical director at General Motors Corporation in Warren and served on the admitting staff of Wheelock Memorial Hospital in Goodrich, St. Joseph Mercy Hospital in Pontiac and William Beaumont Hospital in Royal Oak. Doctor Baylis received his medical degree in 1952 from the University of Michigan Medical School.

Stuart Bergsma, MD
Tucson (formerly of Grand Rapids)

Doctor Bergsma died July 30 at the age of 86. Doctor Bergsma received his medical degree from Calvin College Rush Medical School of the University of Chicago and the School of Tropical Medicine and Hygiene in London, England. He served as a medical missionary for 16 years, six years in Ethiopia and 10 years in India. Doctor Bergsma also maintained a general practice as a surgeon in Grand Rapids between missionary assignments. He was a member of the American College of Surgeons, American Psychiatric Association, Michigan State Medical Society, Kent County Medical Society and the Christian Medical Soc ety. Doctor Bergsma was also the retired superintendant of Pine Rest Christian Hospital.

William E. Brown, III, MD
Ann Arbor

Doctor Brown died July 13 at the age of 63. Doctor Brown received his medical degree in 1946 from the University of Michigan Medical School. He was a surgeon at St. Joseph Mercy Hospital for approximately 35 years. He also directed the education program for the Department of Surgery and was secretary of the medical staff while at St. Joseph Mercy Hospital. Doctor Brown was a clinical professor of surgery at the University of Michigan Medical School.

Manley J. Capron, Jr, MD
Battle Creek

Doctor Capron died June 10 at the age of 68. Doctor Capron received his medical degree from Western Reserve University Medical School in Ohio in 1943. Doctor Capron was an active senior staff member at Leila Hospital and formerly had held that position at the old

Continued on page 57

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Battle Creek Sanitarium Hospital. He entered the Navy during World War II, and left active duty in 1958 as a captain. After leaving the Navy he returned to Battle Creek and joined his father in private practice until his retirement in 1985.

Dean P. Carron, MD
Ann Arbor
Doctor Carron died July 31 at the age of 65. Doctor Carron was chief of staff at Mercywood Hospital and chief of the Psychiatric Department at St. Joseph Mercy Hospital. Doctor Carron received his medical degree from Wayne State University School of Medicine in 1945. He served as president of the Michigan Psychiatric Society and was a member of the board of directors of the Michigan Society for Mental Health. He also served as president of the Ann Arbor Family Service board and was appointed regional vice president of the Family Service Association of America. Doctor Carron served as delegate from 1962-73 and alternate from 1974-75 to the MSMS House of Delegates.

James E. Collins, MD
Detroit
Doctor Collins died February 25 at the age of 69. Doctor Collins received his medical degree in 1943 from Wayne State University College of Medicine. He served in the Army medical corps as a lieutenant from 1943 to 1946. Doctor Collins served his internship and had postgraduate training in general internal medicine at Grace Hospital in Detroit. He maintained a practice in Southfield.

Basil R. Dickson, MD
Detroit
Doctor Dickson died June 18 at the age of 84. Doctor Dickson, an X-ray therapy specialist, received his medical degree from the University of Toronto Medical School in 1926. He moved to Detroit in 1928 and opened a practice on West Grand Boulevard which he maintained until his retirement in the early 1970s. Doctor Dickson was a member of the Wayne County Medical Society, and the American Radium Society.

Simon Dolin, MD
Southfield
Doctor Dolin died May 27 at the age of 73. Doctor Dolin was a nationally and internationally renowned authority on X-ray diagnosis and treatment of bone disease. He received his medical degree in 1938 from the University of Lithuania Medical Facility. He was chief of radiology at North Detroit General Hospital for seven years. Doctor Dolin was a professor of radiology at Wayne State University School of Medicine, and he maintained a private practice in Detroit for 29 years before retiring in 1985.

Boy Frame, MD
Grosse Pointe Park
Doctor Frame died August 16 at the age of 63. Doctor Frame was chairman of the Department of Medicine at Henry Ford Hospital and had won international recognition for his work on bone and mineral diseases. He received his medical degree in 1948 from Yale University School of Medicine and began working at Henry Ford in 1956. Doctor Frame was a regent at the American College of Physicians and was Michigan governor of the organization. He was appointed to the Life Sciences Committee of the National Aeronautics and Space Administration. Doctor Frame became clinical professor of internal medicine at the University of Michigan Medical School in 1970 and held that position until his death.

Lawrence W. Gardner, MD
Birmingham
Doctor Gardner died June 18 at the age of 75. Doctor Gardner was director of pathology at Mt. Carmel Mercy Hospital from 1945-71. He was forme president of the Michigan Blood Bank and also of the Michigan Society of Patholog Doctor Gardner received his medical degree in 1939 from Wayne State University Schoo of Medicine. He was a memb of the American Association Pathologists and Bacteriologists and the International Academy of Pathologists.

Otto S. Hult, MD
Gladstone
Doctor Hult died July 11 at th age of 84. Doctor Hult received his medical degree from the University of Michigan Medical School in 1929. After serving his residency in Detroit he returned to Gladstone and set up practice which he maintained for 46 years before his retirement in 1977. Doctor Hult was active in community affairs, served a a member of the Gladstone School Board for 20 years, an was a past president of the Delta County Medical Society.

Karl Klicka, MD
Belleville
Doctor Klicka died June 24 at the age of 74. Doctor Klicka was a retired executive director of the five-hospital group operated by the Peoples Community Hospital Authority. He served on the board of the Michigan Hospital Association and also was a member of a blue-ribbon committee formed by the Detroit Area Hospital Council to implement recommendations for effective emergency medical service in the metro Detroit area. Doctor Klicka received his medical degree in 1937 from the Case Western Reserve School of Medicine.

Earl G. Krieg, MD
Marine City
Doctor Krieg died July 20 at the age of 84. Doctor Krieg was a founding member of the Detroit Surgical Association. He received his medical degre

1925 from Wayne State Uni-
ersity School of Medicine. He
erved as acting administrator
f Detroit Receiving Hospital
uring World War II, and he
erved 20 years as chief of sur-
ery at Cottage Hospital and
St. John Hospital. Doctor
rieg was a diplomate of the
merican Gastroenterology So-
ety. Doctor Krieg retired
om medical practice in 1964.

aymond Laige, MD
rosse Pointe Park
octor Laige died July 15 at
e age of 84. Doctor Laige
eceived his medical degree in
927 from St. Louis University
chool of Medicine. He served
s a lieutenant colonel in the
S Army during World War II.
octor Laige was a retired sur-
eon who served his internship
t Providence Hospital before
ecoming a surgeon at Marine
ospital, Seattle. He later
erved as a surgeon at Percy
ones Hospital in Battle Creek
nd served as a Chrysler Corporation physician until his retirement 19 years ago.

Mark McQuiggan, MD
Detroit
Doctor McQuiggan, 85, died June 1. He received his medical degree from the University of Pittsburg in 1923. Doctor McQuiggan opened his practice in 1929 with his wife, Catherine Corbeille, MD. He was recipient of a Mayo Clinic Fellowship and was an assistant professor at the Wayne State University School of Medicine. Doctor McQuiggan was a member of the American College of Physicians and the American Diabetes Association. He retired from practice in 1973.

Stuart F. Meek, MD
Stevensville
Doctor Meek died August 16 at the age of 81. Doctor Meek, and obstetrician/gynecologist, received his medical degree in 1934 from Wayne State University School of Medicine. He served his postgraduate training at Highland Park General Hospital from 1933 to 1934 and maintained a practice until his retirement in 1971.

Bhupendra H. Nanavati, MD
Hancock
Doctor Nanavati died July 16 at the age of 45. Doctor Nanavati received his medical degree from Seth G.S. Medical College in Bombay, India in 1966. He was commended by the Keweenaw Bay Indian Tribal Council for 10 years of medical service to the tribe. He served his internship at Manchester Memorial Hospital, Connecticut and postgraduate training at Duval Medical Center, Florida and South Baltimore Hospital, Maryland. Doctor Nanavati maintained a practice in internal medicine/nephrology in Hancock.

Continued on page 574

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Burns G. Newby, MD
Birmingham
Doctor Newby died August 22 at the age of 64. Doctor Newby was a plastic surgeon and was program director and head of residency for Mt. Carmel Mercy Hospital in Detroit. He served as chief of plastic surgery for 15 years at Providence, Mt. Carmel Mercy and Sinai Hospital in Detroit. Doctor Newby was past president of the Michigan Plastic Surgeons Association. He graduated in 1946 from the University of Utah Medical School and served on staff at Harper-Grace Hospitals, Hutzel Hospital, Pontiac General, William Beaumont and Madison Community Hospital.

John R. Power, MD
Battle Creek
Doctor Power died July 2 at the age of 68. Doctor Power was a obstetrician/gynecologist who maintained a practice in Battle Creek for 33 years before his retirement in 1983. Doctor Power was a member of the American Medical Association, Calhoun County Medical Society and served on the staff of both Community and Leila hospitals.

Earl A. Rinkenberger, MD
Mio
Doctor Rinkenberger died July 26 at the age of 62. Doctor Rinkenberger received his medical degree in 1952 from Johns Hopkins University Medical School. He was a staff member at St. Joseph Hospital and a member of the Macomb County Medical Society. Doctor Rinkenberger maintained his internal medicine practice in Mount Clemens until his death.

Peter Sauer, MD
Owosso
Doctor Sauer died June 18 at the age of 63. Doctor Sauer was an obstetrician/gynecologist and partner in the Owosso Medical Group. He served on staff of Memorial Hospital. He received his medical degree from the School of Medicine at the Ludwig Maximilians Universitate in Munich, Germany in 1952. Doctor Sauer served as secretary/treasurer and former president of the Shiawassee County Medical Society. He was also a Clinical Assistant Professor at the College of Human Medicine, Michigan State University.

Richard C. Schneider, MD
Ann Arbor
Doctor Schneider died June 9 at the age of 73. Doctor Schneider was professor emeritus and former head of neurosurgery at University of Michigan Medical Center. He received his medical degree from the University of Pennsylvania Medical School in 1939 and had been a member of the University of Michigan faculty since 1946. Doctor Schneider established the neurosurgery service at St. Joseph Mercy Hospital and served as its chief until 1969. He became head of of the section of neurosurgery in 1969 and retired as professor emeritus in 1983.

Howard A. Schuneman, MD
Bloomfield Hills
Doctor Schuneman died August 28 at the age of 75. Doctor Schuneman received his medical degree in 1937 from the University of Michigan Medical School. He served on staff for 31 years at William Beaumont Hospital, Royal Oak and was named physician emeritus. Doctor Schuneman maintained a practice for many years in Pleasant Ridge before retiring in 1982. He was a charter member of the American Association of Family Physicians.

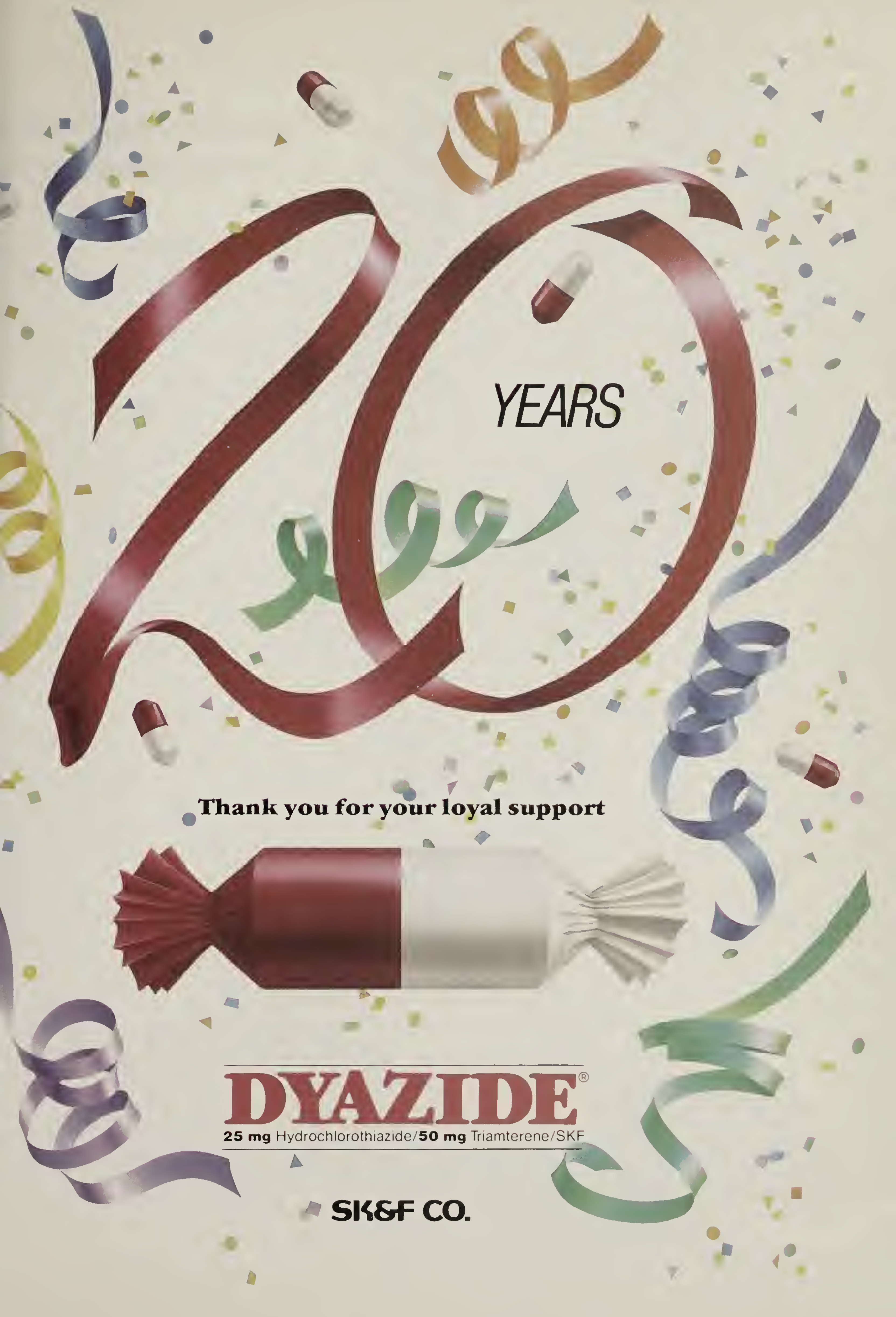
Henry L. Smith, MD
Birmingham
Doctor Smith died August 10 at the age of 89. Doctor Smith was a specialist of cardiovascular disease and was a founding member of the Michigan Heart Association. He was appointed to the staff of Mt. Carmel Mercy Hospital in 1939 and had served as chairman of the Department of Internal Medicine and as hospital chief of staff. Doctor Smith received his medical degree in 1922 from the University of Michigan Medical School. He was a fellow of the American College of Physicians, a member of the Detroit Heart Club, and the World Medical Association. Doctor Smith retired in 1972 after 50 years of private practice in Detroit.

Stanley M. Smyka, MD
Grosse Pointe Woods
Doctor Smyka died May 28 at the age of 69. Doctor Smyka received his medical degree in 1943 from Loyola University School of Medicine. He was a captain and battalion surgeon with the Army 42nd Division during World War II. In addition to maintaining a practice for 30 years in East Detroit, he was the father of 11 children. He was a member of the American College of Surgeons.

Morris L. Sorkin, MD
Flint
Doctor Sorkin died September 7 at the age of 74. Doctor Sorkin received his medical degree from Wayne State University School of Medicine in 1939 and served in the US Army Medical Corps as a Captain from 1942-45. He served as chairman on the Medical Advisory Board of Medical Assistants. Doctor Sorkin was a member of the Michigan Society of Anesthesiologists, the American Society of Anesthesiologists, and Genesee County Medical Society.

Wallace H. Steffensen, MD
Grand Rapids
Doctor Steffensen died August 16 at the age of 79. Doctor Steffensen was a developer of modern plastic surgery and a world-renowned surgeon. He received his medical degree in 1931 from the University of Michigan Medical School. Doc-

Continued on page 579



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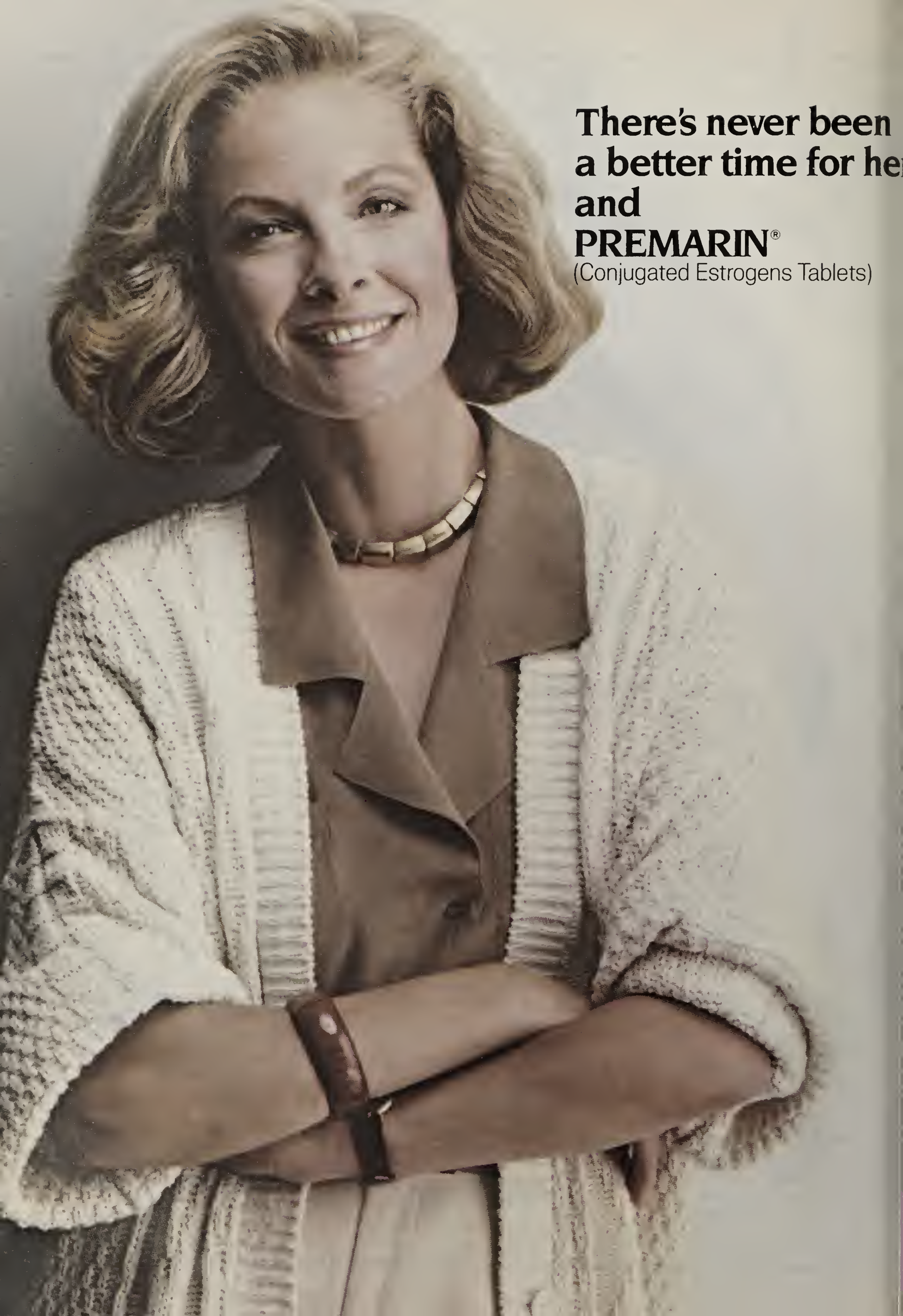

There's never been
a better time for he
and
PREMARIN®
(Conjugated Estrogens Tablets)

Now the evidence looks better than ever

Significantly reduced risk of endometrial hyperplasia

Endometrial hyperplasia was significantly reduced when progestin was added to PREMARIN therapy for more than ten days a month.[1-4] The risk of endometrial hyperplasia may also be reduced through cyclic administration of unopposed, low-dose PREMARIN.

Effect on lipids—an important feature

PREMARIN used alone does not adversely affect lipid levels. In fact, a clinical study has shown a significant increase in HDL cholesterol—from 49.7 mg/dL to 56.4 mg/dL—and decrease in LDL cholesterol—from 165.1 mg/dL to 138.1 mg/dL—after one year of therapy with PREMARIN, 0.625 mg.[5]

Low-dose control of menopausal symptoms*

PREMARIN effectively relieves vasomotor symptoms, such as hot flashes. When estrogen deficiency is limited to atrophic vaginitis, PREMARIN® (conjugated estrogens) Vaginal Cream restores the vaginal environment to its premenopausal state.

The most widely used, most extensively studied estrogen worldwide.

PREMARIN®

(Conjugated Estrogens Tablets)

Most trusted for more reasons

*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

For moderate-to-severe vasomotor symptoms

PREMARIN®

(Conjugated Estrogens Tablets)

PREMARIN 0.3
PREMARIN 0.625
PREMARIN 0.9
PREMARIN 1.25
PREMARIN 2.5

0.3 mg 0.625 mg 0.9 mg 1.25 mg 2.5 mg

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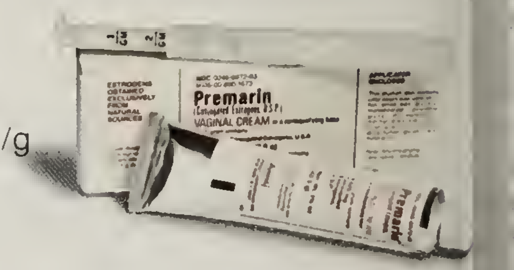
For atrophic vaginitis

PREMARIN®

(Conjugated Estrogens)

Vaginal
Cream

0.625mg/g


ESTROGENS OBTAINED EXCLUSIVELY FROM NATURAL SOURCES
Premarin
(Conjugated Estrogens U.S.P.)
VAGINAL CREAM
Premarin

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream in a nonliquefying base

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13 9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses.

2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects One case control study estimated a 4.7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion) Some of these exposures were very short and involved only a few days of treatment The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000 In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1 25 mg, and 2.5 mg strengths of conjugated estrogens Cream is available as 0 625 mg conjugated estrogens per gram

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) **Osteoporosis (abnormally low bone mass).** Atrophic vaginitis Kraurosis vulvae Female castration

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens (See PRECAUTIONS) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease 2 Known or suspected estrogen-dependent neoplasia 3 Known or suspected pregnancy (See Boxed Warning) 4 Undiagnosed abnormal genital bleeding. 5 Active thrombophlebitis or thromboembolic disorders 6 A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans. (See Boxed Warning) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estr
per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increa
risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this si
used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tende
abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estr
containing oral contraceptives Increased blood pressure may occur with use of estrogens in the menopaus
blood pressure should be monitored with estrogen use A worsening of glucose tolerance has been obser
patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be ca
observed Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metasta

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior
initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic or
and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longe
one year without another physical examination being performed Conditions influenced by fluid retention su
asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patient
develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine blee
mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase th
of endometrial hyperplasia in some patients Oral contraceptives appear to be associated with an incre
incidence of mental depression Patients with a history of depression should be carefully observed. Preex
uterine leiomyomata may increase in size during estrogen use The pathologist should be advised of est
therapy when relevant specimens are submitted If jaundice develops in any patient receiving estrogen
medication should be discontinued while the cause is investigated. Estrogens should be used with care in pat
with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia,
young patients in whom bone growth is not complete If concomitant progestin therapy is used, potential
may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

a Increased sulfobromophthalein retention

b. Increased prothrombin and factors VII, VIII, IX, and X, decreased antithrombin 3; increased
epinephrine-induced platelet aggregability.

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone
measured by PBI, T4 by column, or T4 by radioimmunoassay Free T3 resin uptake is decreased, reflectin
elevated TBG; free T4 concentration is unaltered

d Impaired glucose tolerance.

e. Decreased pregnanediol excretion.

f. Reduced response to metyrapone test

g Reduced serum folate concentration.

h Increased serum triglyceride and phospholipid concentration. As a general principle, the administratic
any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in hu
milk

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contracept
breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndro
amenorrhea during and after treatment; increase in size of uterine fibromyomata, vaginal candidiasis, chang
cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secre
(of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma w
may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; los
scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migra
dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggr
tion of porphyria; edema; changes in libido

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1 *Given cyclically for short-term use only* For treatment of moderate to severe *vasomotor* symptoms, atro
vaginitis, or kraurosis vulvae associated with the menopause (0 3 to 1.25 mg or more daily). The lowest dose
will control symptoms should be chosen and medication should be discontinued as promptly as possi
Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or ta
medication should be made at three- to six-month intervals

2 *Given cyclically* Female castration Osteoporosis Female castration—1.25 mg daily, cyclically Ad
upward or downward according to response of the patient For maintenance, adjust dosage to lowest level
will provide effective control Osteoporosis —0 625 mg daily. Administration should be cyclic (eg, three we
on and one week off).

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measu
taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only For treatment of atrophic vaginitis or kraurosis vulvae

The lowest dose that will control symptoms should be chosen and medication should be discontinued
promptly as possible

Administration should be cyclic (eg, three weeks on and one week off)

Attempts to discontinue or taper medication should be made at three-to-six month intervals

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer a
appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurr
abnormal vaginal bleeding

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acetate treatment in postmenopausal women *Obstet Gynecol* 1985;66:216-219

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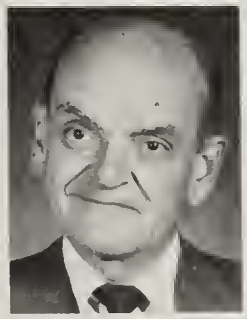
Steffensen was a founding
mber of the American As-
ciation of Plastic Surgeons
d served as its secretary and
asurer from 1947 until
51. He also served as presi-
nt of the American Society
Plastic and Reconstructive
rgery. In 1959 Doctor
effensen was selected by the
State Department as a
mber of a six-man team of
stic surgeons to participate
an exchange program to
dy plastic surgery in the
viet Union.


Sweeny

onald N. Sweeny, Jr., MD
rosse Pointe Farms
octor Sweeny, former mem-
r of the MSMS Board of
rectors, died September 8 at
e age of 72. He had held
any influential medical posts,
cluding: chairman, AMA
ouncil on Medical Service;
esident, Detroit Academy of
irgery and Detroit Surgical
ociety; trustee, American As-
ociation of Medical Clinics;
SMS judicial commissioner;
airman, MSMS Legal Affairs
ommittee; member, Executive
ommittee, Greater Detroit
rea Hospital Council, Inc.;
ember, Medical Practice
oard; secretary and trustee,
ayne County Medical Society.
e had been a member of the
on Secours Hospital staff
nce 1947, was chief surgeon
om 1969-71, and president
f the medical staff from
977-78. He had been editor
nd associate editor of the
etroit Medical News. Doctor Sweeny helped form the department of religion and medicine for the American Medical Association.

Elmer H. Tofteland, MD
Flint
Doctor Tofteland died June 20 at the age of 74. Doctor Tofteland received his medical degree from the University of Minnesota Medical School in 1938. He moved to Detroit that same year to serve his residency and internship, then he moved to Flint in 1940. There he began a private practice in internal medicine which he maintained for over 40 years. Doctor Tofteland was a member of the Genesee County Medical Society.

Clarence Weaver, MD
Deerfield Beach, FL (formerly of Detroit)
Doctor Weaver died April 15 at the age of 92. Doctor Weaver began his medical education at the George Washington University Medical School and graduated from Wayne State University School of Medicine in 1917. Doctor Weaver spent the majority of his medical career in practice in Detroit until his retirement in 1956. He was an emeritus member of the Radiological Society of North America, a life member of the Wayne County Medical Society, and a retired fellow of the American College of Radiology.

Peter P. Werle, MD
Grosse Pointe Shores
Doctor Werle died July 5 at the age of 75. Doctor Werle received his medical degree from the Western Reserve University School of Medicine in 1936. He moved to Detroit in 1948 and joined the staff of Henry Ford Hospital where he practiced radiology. In 1958 he became a medical staff member at Alexander Blain Memorial Hospital and served as chief of radiology from 1964-73. Doctor Werle practiced in Detroit for 32 years before his retirement in 1980.

Robert K. Whiteley, MD
Grosse Pointe
Doctor Whiteley died September 9 at the age of 77. Doctor Whiteley received his medical degree from the University of Michigan Medical School in 1933. He served on the staffs at Harper Jennings Memorial and Bon Secours Hospital. Doctor Whiteley was a former the president of the Wayne County Medical Society, was Delegate and Councilor to Michigan State Medical Society, chairman of the Finance Committee for Michigan State Medical Society, and member and former president of the Grosse Pointe Board of Education. Doctor Whiteley maintained a practice in obstetrics and gynecology in Detroit until his retirement.

John P. Williams, MD
West Bloomfield
Doctor Williams died July 31 at the age of 67. Doctor Williams received his medical degree in 1941 from Wayne State University Medical School. He then served as a flight surgeon in the US Air Force during World War II. Doctor Williams returned to Michigan and set up a private practice in Pontiac which he maintained for 37 years until his retirement in 1982. He served as chief of staff at Pontiac General Hospital from 1955-56, and was a member of the Michigan Academy of Family Practice.☐

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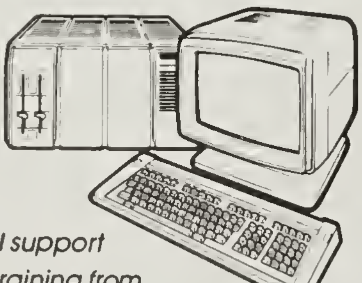

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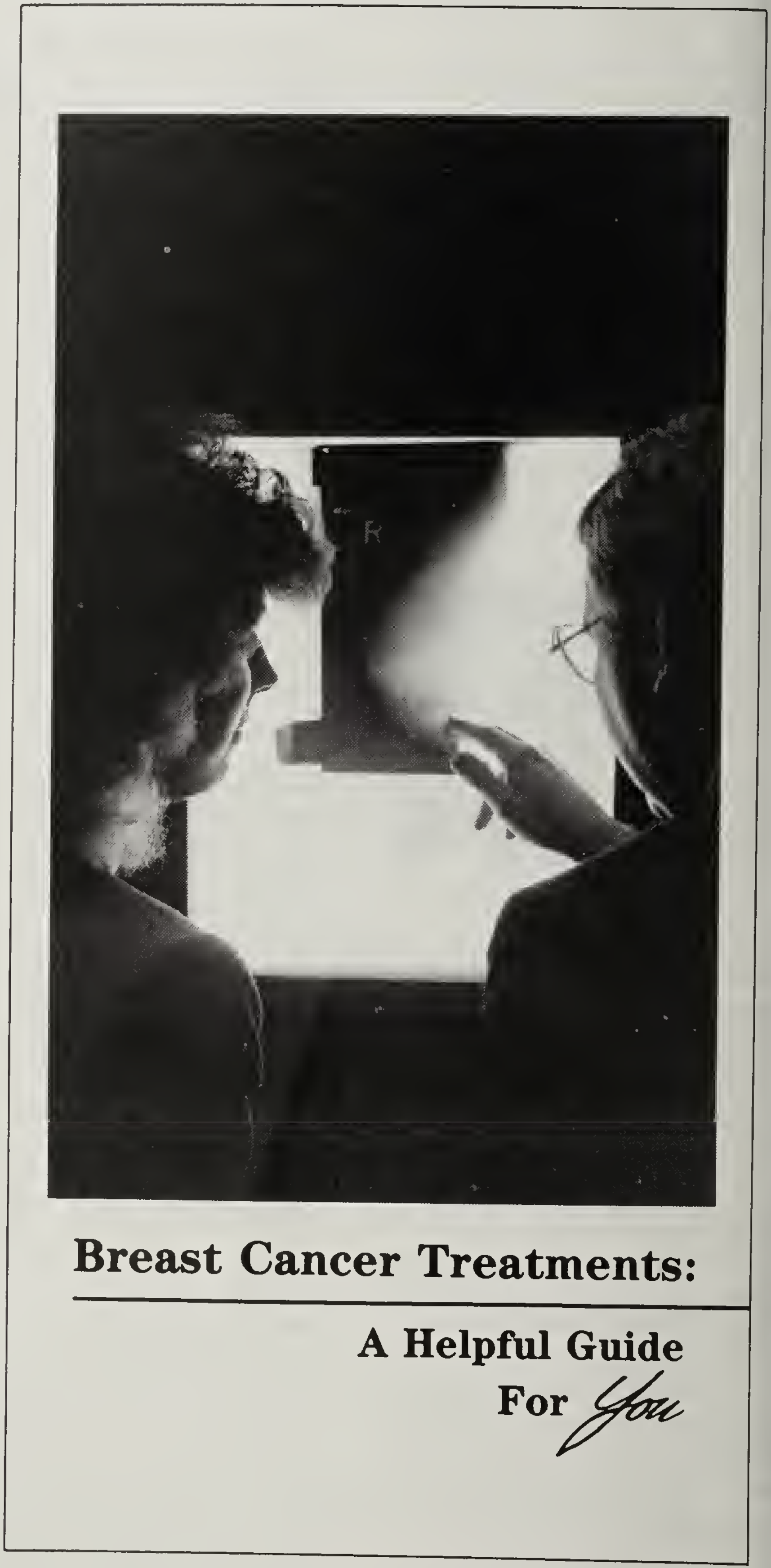

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From discovering a lump to recovering from surgery or other treatment — a new MSMS brochure details the steps taken wher breast cancer is diagnosed. "Breast Cancer Treatments: A Helpf Guide for You" is a pamphlet desired to answer many of the qu tions and allay some of the fears your patients will have.

Fifty copies are available to you at no charge by writing Joyce Crum, Michigan State Medical Society, 120 W. Saginaw, East Lansing 48823.

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MARM meets to further risk management

Medical Associations for Risk Management (MARM), is a corp ration established to study and conduct medical risk manageme activities to improve health care It met for the first time September 17 at MSMS headquarters. Gerald H. Mandell, MD, seated a head of table, appointed the MARM board of directors and di cussed the structure and functio of the group's finance and opera tions committees. Committee members represent professional and hospital liability insurers an the Michigan Society of Hospital Risk Management. Michael Hard of the Michigan Hospital Associa tion Mutual Insurance Company standing.

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Orlando, FL:
☐ Friday, December 12

Atlanta, GA:
☐ Wednesday, December 3

Chicago, IL (AMA):
☐ Thursday, November 6
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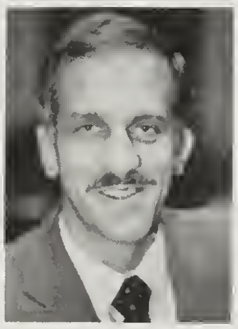
By Carole Ebe

Representative Donald Van Singel —

He serves terms “one at a time’



Van Singel

Few legislators are humble enough to list their occupation as vegetable farmer.

Meet Rep. Donald Van Singel (R-Grant). No fancy titles, no unintelligible euphemisms. Just plain vegetable farmer.

Just as refreshingly straightforward as his occupation, he freely admits he fits the image of, “You can take the boy out of the country, but you can't take the country out of the boy.”

“I enjoy politics,” he says, reflectively. “Yeah, I must. I'm still at it (after 14 years in the House). But, like any job, it has its good days and bad days. Sometimes it wears at me after a while.

“I miss horticulture to some extent, although I still have an interest in a family operation. I try to get back there in the summer and see what's going on. But I don't have much time to get real involved.”

One at a time

While others are busy plotting their lives to encompass grandiose schemes, Van Singel says he has no idea what he'll be doing ten years from now.

“Since I've been here, I've had the philosophy of taking one term at a time,” he says. “I play it by ear and see how it goes. There's not a lot of job security here, so I just go along one term at a time.”

Van Singel, however, is one of the fortunate ones in the legislature coming from a solid party — Republican, in this case — district.

Still, he adds, there are always surprises during elections. You can never quite be sure if you're returning.

After 14 years in the minority party, Van Singel says it would be nice to be in the majority for a change.

“Republicans have a good shot at taking control this election,” he says. “It could be fairly easy with the candidates we have. It's quite feasible. At the same time, the Dems have a shot at taking a couple away from us.”

With a 57-53 Democratic edge in the House now, he says six to 12 seats are considered up for grabs.

But whatever happens, Van Singel is pragmatic in his views — an attitude that comes in handy for his job as Republican floor leader. As floor leader, he must help legislation flow through the chamber.

“Regardless of which party is in the minority, you can't adopt an attitude of being an obstructionist and hold up traffic, so to speak,” he said. “You have to have an attitude that, ‘I have some views that I would like injected into legislation and I will try my utmost to do that.’

“Win or lose, at that point you have to move on,” he continues. “There are other players, there is another House for the legislation.”

Issues he sees as looming large in the 1987 session are refinancing of school aid to shift the burden away from property taxpayers and some fine tuning of the liability insurance issue.

“I guess considering all the different special interest groups and where they came from, perhaps we came up with as close to what could b expected with a compromise,” says Van Singel, who also sits on the House Insurance Committee, about the liability issue. “However, I was a little disappointed we didn't push a little harder on tort reform.”

He said the legislature has put a band-aid on the problem but much work remains to be done.

“We can't afford to rest on our laurels and say we've addressed the issue of liability and insurance and tort reform, so we've taken care of the problem,” he says. “We shoul not assume it's all solved at this point. There will be some changes as we see how the courts implement what we've passed and how the interpretations are.”

Van Singel says he has had good relationship with Robert Paxton, MD, chairman of the MSMS Board of Directors, since his early days in the legislature because the physician made the effort to get to know him.

“You can write a letter, and that has an impact,” he said. “Or you can get on the phone and call, and that has an impact. But if you get to know your legislators, get involved in their campaigns, and get to know them on a first name basis, then you'll have a much *greater* impact.”☐

Ms. Eberly is a Lansing-area free-lance writer.

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- **"PET and SPECT: Imaging of Normal and Abnormal Brain Physiology"**
  Michael J. Gelfand, MD, Associate Professor of Radiology - University of Cincinnati Medical Center
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  Ernest Ring, MD, Professor of Radiology - University of California, San Francisco
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Gubernatorial candidate

By Gov. James J. Blancha

Blanchard

When I first took office, controlling health cost increases was a high priority for my administration. Through the combined efforts of government, the business community, health professionals, and third-party payers, consumers and other purchasers of health care we have had a significant impact on this issue. A new era of increased competition has evolved and I expect this trend to continue in the months and years ahead. Although I welcome many aspects of this new competitive environment, we must continue to work closely together to be certain that access and quality are not jeopardized by inappropriate forms of competition. Therefore, it is important that controlling health care costs be balanced against the equally important concerns of access and quality.

Recently, our attention has shifted away from these important objectives and has focused on the increasingly serious liability insurance crisis. Although the liability insurance crisis has permeated nearly every level of activity in this state, high risk areas such as medicine have been extremely hard hit. The complexities of this problem have made it very difficult to isolate causes and even more difficult to reach consensus on proposed solutions. The recently passed package of legislation represents an important first step, one which I believe will begin to have an impact in the months ahead. However, it is critical that both government and the private sector monitor this situation carefully in the months ahead. If these reforms prove to be ineffective or insufficient, I am prepared to consider other approaches and options as appropriate.

Although the liability insurance crisis remains at the top of my list of concerns for health care, a number of other areas require attention. These include careful monitoring of AIDS and efforts to prevent its spread, increased attention to the unacceptable infant mortality rates which we have experienced in some areas of Michigan, and improvements in long term care. I am especially concerned about recent trends in nursing home care, a matter which is now under review by an inter-departmental task force, working cooperatively with the private sector. I am also committed to further progress in improving the efficiency of our state Medicaid program. However, this must be accomplished without further penalizing those providers who have been willing to serve our Medicaid recipients.

Another area of concern is the estimated 900,000 Michigan citizens who lack any typ of public or private health coverage. As our economic si uation continues to improve, this number should diminish. However, some will continue to have difficulty obtaining health care coverage. It is essential that input from all seg ments of our economy and th health provider community be considered as we attempt to develop feasible approaches t this problem.

Care for the aged

I am also aware of the unique health care problems facing our increasingly elderly population. Chronic diseases, alternatives to institutional care, and access to care are important matters which require ongoing review. Although Medicare has had a major impact, gaps continue t exist and recent trends seem likely to shift more of this burden to the states. We must begin now to plan ways of meeting these new demands on Michigan's financial and professional resources.

These are just a few of the many health care issues confronting both government and the private sector. The health of our citizens and the system we devise to deliver and pay for health care are dynamic and demand our constant attention. New problems and new challenges are just around the corner. I am hopeful that the spirit of cooperation will continue to prevail as we confront these uncertainties.

Gov. Blanchard, a Democrat, was elected in 1982 and seeks reelection.

iscuss health care

By William Lucas

Lucas

Considering that I have
three children in medical
ofessions and one child in
edical school, one can im-
gine my interest in health
re issues. With the insight I
ceive through my children,
mbined with my experience
an administrator, I have
en fortunate to obtain a
ell-informed perspective on
e situation.

Clearly the most pressing is-
e of the day concerns the
ofessional liability crisis and
e damaging effect it is hav-
g on the medical community
well as the patients. The
ackage of bills that was re-
ntly signed into law was a
eble attempt to address this
oblem. As a result, the state
still without an effective cap
non-economic awards.

Because the governor has
iled to call for a more com-
ehensive cap on non-
conomic awards, Michigan
ysicians must continue to in-
re against multi-million dol-
r awards. By driving up the
st of insurance, this also
ives up the cost of medical
care. To address this problem, I have proposed allowing full compensation for economic damages and a cap on non-economic awards with no exceptions.

The professional liability crisis will not be solved simply by capping non-economic awards, however. There is also a need for tort reform to limit attorney's fees. I support the recommendation by the US Justice Department to President Reagan to reduce attorney fees by setting up a schedule in which lawyers will get a smaller percentage of the award as the amount of the award increases. Although the exact percentages are open to negotiation, the idea is to keep the award where it should be, in the hands of the victim rather than in the pockets of the attorney.

No solution to the liability problem will be complete without a plan for more effective peer review among those in the medical community. Therefore, I will encourage efforts to bring self-regulation into the industry by urging the creation of private review panels that have the authority to set standards for the responsible practice of medicine.

Outdated regulations

The professional liability crisis is certainly not the only issue facing the Michigan medical community. Michigan's hospitals are burdened with outdated regulations that restrict the availability of health care at reasonable costs. The current requirement that the state must approve all capital expenditures over $150,000 is way off base with national regulations. The state must explore new ways of promoting cost effectiveness in the health care industry without jeopardizing the quality of care. The current administration in Lansing, in keeping with its history of failing to provide leadership, has failed to present any proposal that will solve this crisis. In the meantime, patients throughout Michigan await an answer to the lack of available health care.

Another problem that demands immediate attention is the high infant mortality rate. Michigan's infant mortality rate of 11.7 per 1,000 live births exceeds the national average of 10.6 per 1,000 live births. As county executive, I have led an attack against this problem in Wayne County, where the infant mortality rate is as high as 31 percent in one part of the county. For our efforts we have received a national award recognizing our leadership role in this fight. The largest hurdle in our drive to lower infant mortality rates has been to educate parents of the necessity of prenatal and postnatal care. As governor, I would bring to the entire state the same ideas that we have used in Wayne County in our successful programs to fight infant mortality.

The issues I have mentioned here are of utmost importance because they affect the lives of people throughout this state. Unless we get an administration in Lansing that can make the decisions that I have presented in this article, the crisis will continue and the people of Michigan will suffer from a lack of quality medical care.☐

---

r. Lucas is Wayne County Execu-
ve and Republican candidate for
overnor of Michigan.

MSMS, MSMS/A, AMA & MEDICAL ASSISTANTS

November 7-9 — Michigan Medical Assistants "Grand Affair," Amway Grand Plaza Hotel, Grand Rapids, contact: Caroline Rich, MSMS Headquarters, East Lansing (517) 337-1351.

November 10 — MSMS Auxiliary Board Meeting, MSMS Headquarters, East Lansing, contact: Viola Heins (517) 337-1351.

November 11-12 — AMA National Conference on Medical Technology, Radisson Mark Plaza, Alexandria, Virginia, contact: Andrea Schneider (312)645-4532.

November 19 — MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, contact: William Madigan (517)337-1351.

December 7-10 — AMA Interim Meeting, Las Vegas Hilton, Las Vegas, contact: Bruce Ambrose (517) 337-1351.

January 21, 1987 — MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, contact: William Madigan (517)337-1351.

March 18, 1987 — MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, contact: William Madigan (517)337-1351.

April 24-25, 1987 — MSMS House of Delegates, Amway Grand Plaza, Grand Rapids, contact: William Madigan (517)337-1351.

July 16-19, 1987 — MSMS Board of Directors Midsummer Meeting, Deer Lake, Boyne Mountain, contact: William Madigan (517)337-1351.

OTHER MEETINGS

October 21-22 Ethical and L gal Implications of Joint Ven turing in Catholic Health Car Westin Hotel Renaissance Center, Detroit, contact: Department of Education, Th Catholic Health Association, 4455 Woodson Road, St. Louis, MO 63150-0082 (314)427-2500.

October 28 — The Selective Contracting Strategy: Two Pe spectives, Hotel St. Regis, Detroit, contact: June Zimme man, Greater Detroit Area Health Council, (313) 963-4990.

October 31 — Conference o AIDS, Detroit, contact: Robe Tell, Greater Detroit Area Health Council, Inc. (313) 963-4990.

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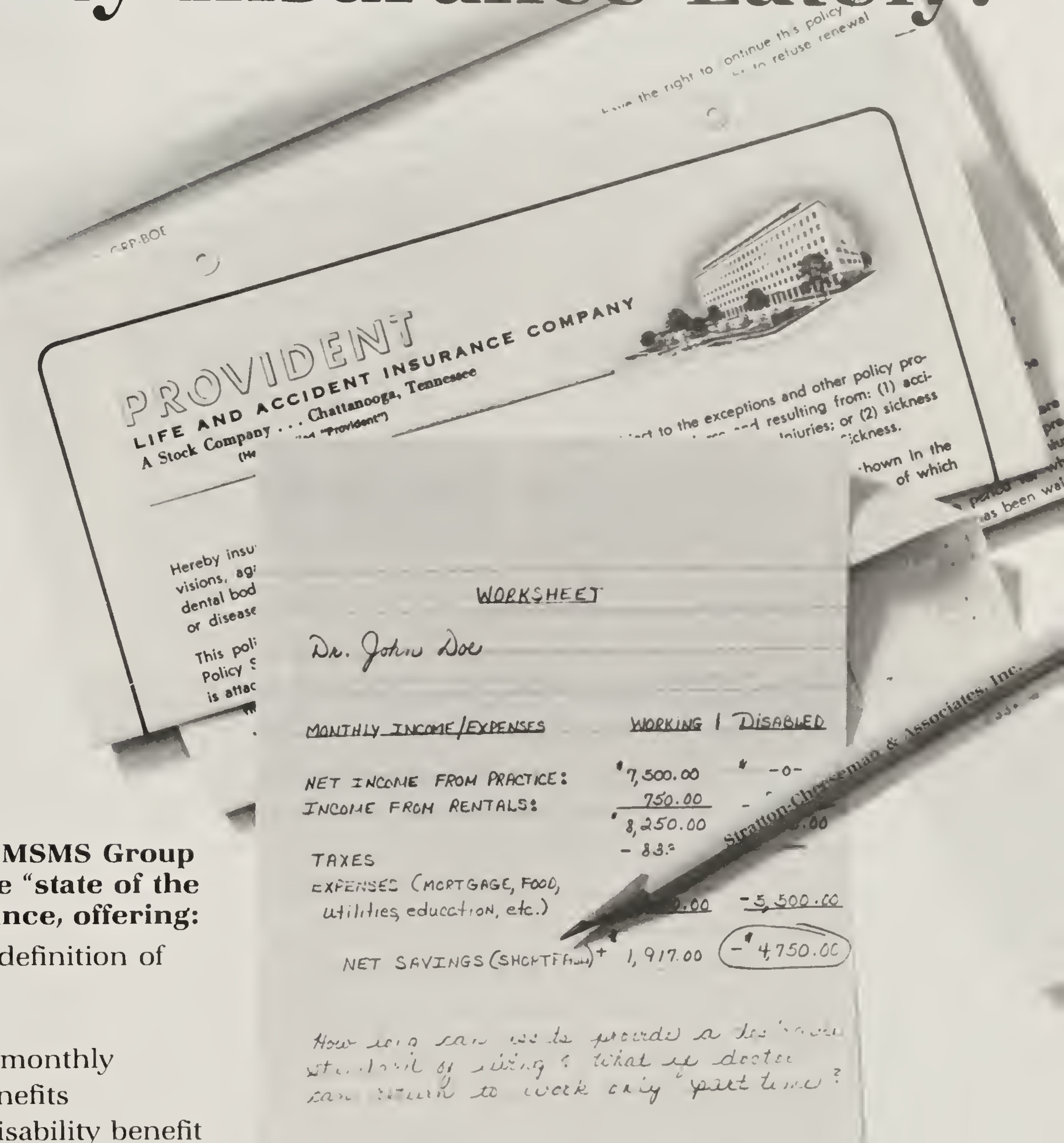
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Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

Date: October 22, 3rd Annual Conference on Alcoholism. Location: Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Kalamazoo Alcohol & Drug Abuse Council; Southwestern Michigan Area Health Education Center; Gateway Villa; American Academy of Family Physicians. **Contact:** Charles L. Zeller, MD, 4th Floor Stryker Center, 1521 Gull Road, Kalamazoo, MI 49001 (616)388-7877. **Approved for: 6 hours of Category I Credit.**

Date: October 22, Rheumatology Day III. Location: Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital Continuing Medical Education Committee. **Contact:** Carol Mastroianni, Program Coordinator, CME, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313)343-3877. **Approved for:** 8 hours of Category I Credit.

Date: October 24-25, Advances in Multidisciplinary Approaches in the Treatment of Cancer of the Breast, Head and Neck, and Ovaries. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 10.5 hours of Category I Credit.

Date: October 24, Basic Cardiac Life Support Course for Physicians. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 6 hours of Category I Credit.

Date: October 24-25, Clinical Oncology. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Janet Boomer, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313)763-1400. **Approved for** 10.5 hours of Category I Credit.

Date: October 25, Advanced Cardiac Life Support Course Recertification. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 8 hours of Category I Credit.

Date: October 25, Coronary Artery Disease: Reducing the Risk and Treating the Problem. Location: Livonia West Holiday Inn, Livonia. **Sponsor:**American Heart Association. **Contact:** Marilyn J. Veltman, American Heart Association, 16310 W. 12 Mile Road, P.O. Box 160, Lathrup Village, Michigan 48076 (313)557-9500. **Approved for:** 6 hours of Category I Credit.

Date: October 25, Reconstruction in Psychoanalysis and Psychotherapy — A Reconsideration. Location: Hyatt Regency Hotel, Dearborn. **Sponsor:** Michigan Psychoanalytic Society. **Contact:** The Michigan Psychoanalytic Society, 16310 West Twelve Mile Road, Suite 204, Southfield 48076 (313) 557-8633. **Approved for:** 6 hours of Category I Credit.

Date: October 25, Primary Care Medicine: A Continuing Series. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Kim Sadlocha, Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3073. **Approved for:** 6.5 hours of Category I Credit.

Date: October 27 and every Monday following for 8 sessions, Special Topics in Psychotherapy. Location: Ann Arbor (site to be announced) **Sponsor:** Michigan Psychoanalytic Institute. **Contact:** Michigan Psychoanalytic Institute, 16310 W. Twelve Mile Road, Suite 204, Southfield 48076 (313)559-5855. **Approved for:** 15 hours of Category I Credit.

Date: October 27-29, Impairment Evaluation and Disability Considerations: Medical and Legal Perspectives. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 17 hours of Category I Credit.

Date: October 30-November 2, Chest Radiology: Pioneers and New Frontiers. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 14 hours of Category I Credit.

Date: November 3-5, 1986 Michigan Statewide Conference on Child Abuse and Neglect. Location: Towsley Center, Ann Arbor. **Sponsors:** University of Michigan Medical School; Michigan Committee for the Prevention of Child Abuse. **Contact:** Gayle Fox, Towsley Center, Box 0201, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 12.67 hours of Category I Credit.

Date: November 4 and every Tuesday following for 4 sessions, Problems in the Psychoanalytic Interpretation of Literature. Location: Ann Arbor (site to be announced). **Sponsor:** Michigan Psychoanalytic Institute. **Contact:** Michigan Psychoanalytic Institute, 16310 W. Twelve Mile Road, Suite 204, Southfield 48076 (313)559-5855. **Approved for:** 15 hours of Category I Credit.

Date: November 5 and every Wednesc following for 6 sessions, The Chan Process in Psychoanalysis: Understar ing Psychoanalytic Technique. Locati Ann Arbor (site to be announced) **Spo sor:** Michigan Psychoanalytic Institu **Contact:** Michigan Psychoanalytic In tute, 16310 W. Twelve Mile Road, Su 204, Southfield 48076 (313)559-58 **Approved for:** 15 hours of Categor Credit.

Date: November 5, Frontiers in Diabe Therapy. Location: Gilmore Center Health Education, Bronson Methodist H pital, Kalamazoo. **Sponsors:** Upjohn Co pany, Southwestern Michigan Area Hea Education Center. **Contact:** Charles Zell Jr., MD, Continuing Medical Educati Office, SMAHEC, Stryker Center, 4th Flo 1521 Gull Road, Kalamazoo, MI 490C **Approved for:** 4 hours of Category Credit.

Date: November 5, 12, 26; December 10; January 7, 14, 21, 1987, Dealing w Resistance in Psychoanalytic Psychoth apy. Location: Michigan Psychoanaly Institute, Southfield. **Sponsor:** Michig Psychoanalytic Institute. **Contact:** Mic gan Psychoanalytic Institute, 16310 Twelve Mile Road, Suite 204, Southfie 48076 (313)559-5855. **Approved for:** hours of Category I Credit.

Date: November 7, 1986, Advanc Cardiac Life Support. Location: Mer Hospital, Muskegon. **Sponsor:** Mercy H pital. **Contact:** Sue Franklin, Box 35 1500 E. Sherman Blvd., Muskegon, 49443 (616) 7252506. **Approved for:** hours of Category I Credit.

Date: November 7, Basic Cardiac Li Support Course for Physicians. Locatio Towsley Center, Ann Arbor. **Sponsor:** U versity of Michigan Medical School. **Co tact:** Anne Karolak, Towsley Center, B 057, U-M Medical School, Ann Arb 48109-0010 (313)763-1400. **Approv for:** 6 hours of Category I Credit.

Date: November 7-9, Tutorial on Manu Medicine Techniques Applied to the E tremities. Location: Kellogg Center, MS **Sponsor:** MSU College of Osteopath Medicine and College of Human Medicin **Contact:** Sandy Kilbourn, Director of Co tinuing Medical Education, MSU, A306 Fee Hall, East Lansing 48824 (517)35 9714. **Approved for:** 24 hours of Cat gory I Credit.

Date: November 8, Complications of Co ticosteriod Therapy. Location: Hen Ford Hospital, Detroit. **Sponsor:** Hen Ford Hospital. **Contact:** Kim Sadloch Henry Ford Hospital, Continuing Medic Education, 2799 W. Grand Blvd., Detrc 48202 (313)876-3073. **Approved for:** hours of Category I Credit.

Date: November 8-9, Advanced Cardi Life Support Provider Course. Locatio Towsley Center, Ann Arbor. **Sponsor:** Ur versity of Michigan Medical School. **Co tact:** Anne Karolak, Towsley Center, Bc 057, U-M Medical School, Ann Arb 48109-0010 (313)763-1400. **Approve for:** 16 hours of Category I Credit.

D e: November 12, Reproductive En- d rinology and Infertility. Location: S.t John Hospital, Detroit. **Sponsor:** S.t John Hospital Continuing Medical E cation Committee. **Contact:** Carol V troianni, Program Coordinator, CME, S t John Hospital, 22101 Moross Road, D oit 48236 (313)343-3877. **Approved f** 8 hours of Category I Credit.

D e: November 11-13, MSMS Annual S ntific Meeting. Location: Hyatt Re- g cy Dearborn. **Sponsor:** Michigan State V dical Society. **Contact:** Sherry Fent, MS Headquarters (517)337-1351. **Ap- p ved for:** 18 hours of Category I Credit.

D e: November 12-14, Real-Time Ultra- s nd in Obstetrics and Gynecology. Lo- c on: Towsley Center, Ann Arbor. **Spon- s** : University of Michigan Medical S ool. **Contact:** Anne Karolak, Towsley C ter, Box 057, U-M Medical School, A Arbor 48109-0010 (313)763-1400. **A roved for:** 21 hours of Category I C dit.

D e: November 13-15, Neonatal/In- f t/Child Life Support. Location: Gil- m re Health Education Center, Kalama- z . **Sponsor:** Southwestern Michigan P inatal Association and Southwestern M higan Area Health Education Center. **C tact:** William H. Scott, MD, South- v stern Michigan Perinatal Association, 2 E. Lovell Street. Kalamazoo 49007 (3)383-6469. **Approved for:** 19 hours of Category I Credit.

Date: November 17-18, Laser Medicine and Surgery: The Aerodigestive Tract. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 17 hours of Category I Credit.

Date: November 17-18, Laser Medicine and Surgery: The Respiratory Tract. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Betty Phillips, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 15.75 hours of Category I Credit.

Date: November 20, Laser Medicine and Surgery: Symposium and "Hands-On" Workshop for Urologists. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Betty Phillips, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 8.3 hours of Category I Credit.

Date: November 19-21, Laser Medicine and Surgery: Specialty Applications. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 22.5 hours of Category I Credit.

Date: November 19, Laser Medicine and Surgery: Symposium and "Hands-On" Workshop for General Surgeons, Thoracic Surgeons, and Gastroenterologists. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Betty Phillips, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 7.75 hours of Category I Credit.

Date: November 21, Laser Medicine and Surgery: Symposium and "Hands-On" Workshop for Gynecologists. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Betty Phillips, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. **Approved for:** 7.5 hours of Category I Credit.

Date: December 6, How to Manage Tachycardias and Bradycardias. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Kim Sadlocha, Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3073. **Approved for:** 6 hours of Category I Credit.

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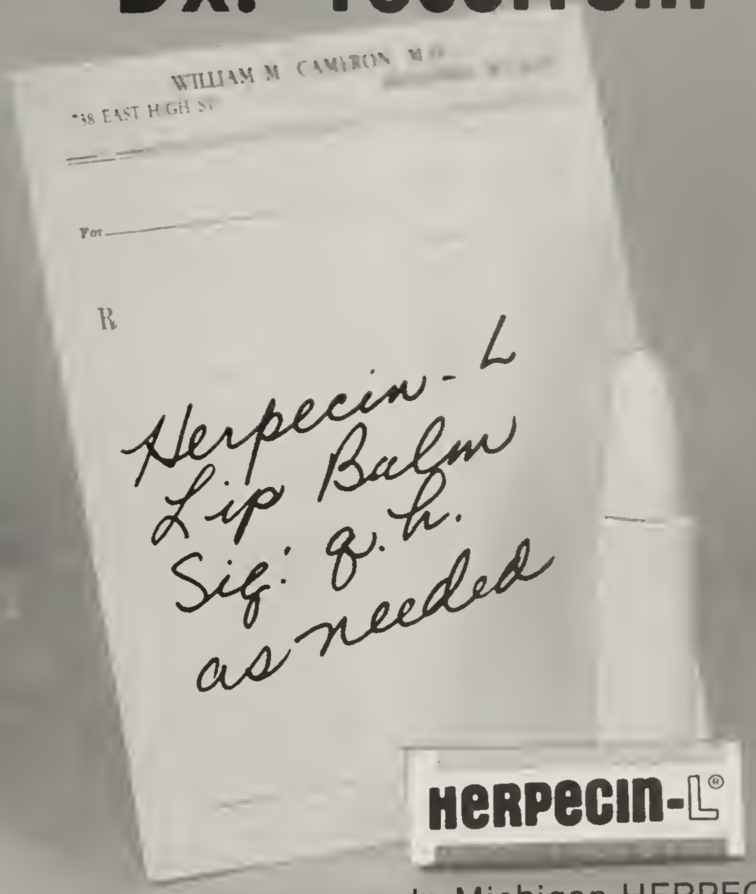

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By Thomas R. Berglund, M

The reason

A few years ago one of my Kalamazoo colleagues told me the only reason he belonged to MSMS was so that he could take advantage of the *INTRAV* trips. These excellent trips *are* one of the benefits of MSMS membership, but I don't think it should be *the* reason!!

In this issue devoted to member benefits you can read all about the many, real, tangible advantages of belonging to MSMS. We have excellent car leasing programs, life insurance policies, group health insurance policies, as well as office VISA and MasterCard programs. In addition, CME opportunities are available at the Annual Scientific Meeting, the Maternal Health Conference, the Sports Medicine Conference and so on. And, of course, there *are* the INTRAV trips.

Connections

MSMS also benefits its members through the Hospital Medical Staff Section. MSMS works with various specialties through the Committee of Specialty Society Presidents. We also have liaison with the Michigan Hospital Association.

In addition, MSMS works for its members with the ongoing negotiations with the Department of Social Services through the Medicaid Task Force. We are presently working on an AIDS educational project with the Department of Public Health. Yearly, MSMS submits nominations to the governor for the Board of Medicine and we have ongoing communication with the Board. Clearly, our membership benefits from these associations.

Any of the above are good enough reasons for belonging to MSMS, but as far as I am concerned they aren't *the* most important reason.

When I was five years old I wanted to be a doctor. Whenever the dentist across the street had company, he would call me over and get me to tell his guests what I wanted to be when I grew up. He thought it was funny because all of the other kids wanted to be train engineers or wanted to be able to drive the Road Commission grader like Mr. Norman. I never faltered in my goal and am proud to have been able to practice medicine for the past twenty-five years.

Yes, I am very proud of my vocation which is one of the most ethical and noble profe sions that I know. Most physicians that I know are honest, hard working, and dedicated their patients. The reason we have continued to be a great profession is because of the forts of MSMS, the AMA, anc the other state medical orgar zations which have worked o our behalf over the years. MSMS has had many dedicate leaders before my time, who have given many hours and much of themselves to keep this profession free and stron Hopefully there will be many more after me.

The reason

This is *the* reason we shoul all belong to and support MSMS. We are all members o our separate specialty organizations, which are mostly scientific, but it is MSMS whi leads the fight for our profession in the state legisature. It is MSMS who battles the regulatory bureacracy on behalf of the membership. It is MSMS that serves as the umbrella organization for all of us.

There are many reasons for and benefits of membership i MSMS. For me *the* main reaso is to keep this *great professic* what it has been in the past, and hopefully will be for our children and grandchildren. ☐

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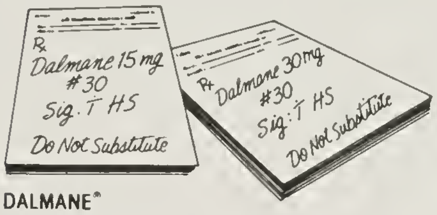

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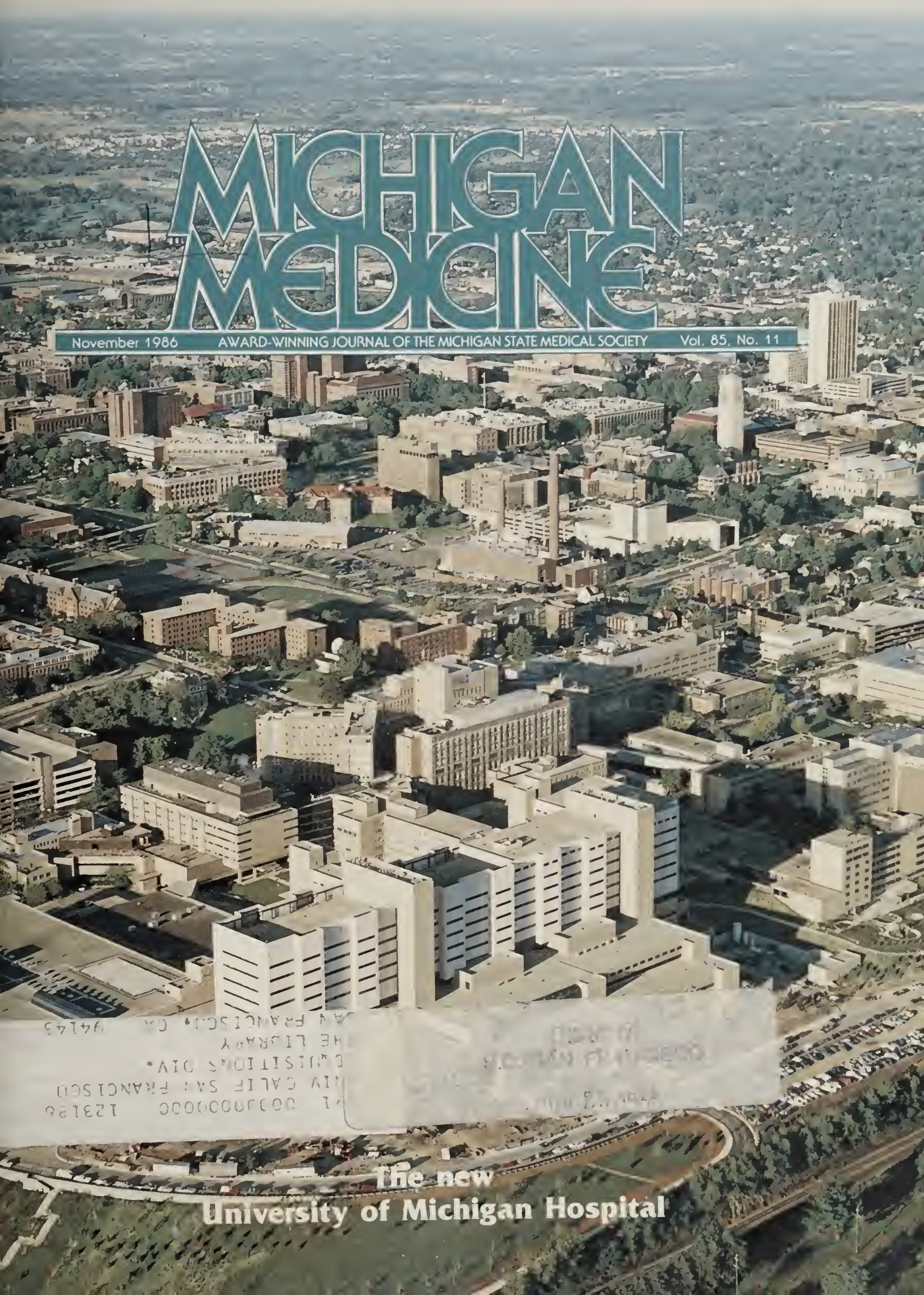
MICHIGAN MEDICINE

November 1986 AWARD-WINNING JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 85, No. 11



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November 1986, Vol. 85, No. 11

MICHIGAN MEDICINE

The new
University of Michigan Hospital

About the cover: More than a decade of planning and four years of construction reached their culmination this summer with the dedication of the University Hospital and A. Alfred Taubman Health Center in Ann Arbor.

In next month's issue of *Michigan Medicine:* Our December Special Report will feature a discussion of MSMS commitments and opportunities in the field of bioethics, and an overview of current bioethical issues.

Special Report

598 More than a million square feet of medical care — that's the new University of Michigan Hospitals complex. It features state-of-the-art technology, architecture and interior design, and is poised to meet the future. Its doors opened in February, and John W. Hall, MD, walked through them recently on assignment to *Michigan Medicine.* His behind-the-scenes look at the new facilities is the heart of our Special Report. Read, too, about the intensive care units, the efficient yet pleasant environment, the robots that roam the complex and the high-tech communication system. Another article details future plans for a Maternal and Child Health Care Center; John W. Hall, MD.

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By Kenneth E. Rowe, MD, MPH

Let's drain the swamp

Most of us have heard some version of the expression, "When you are up to your ears in alligators, it is sometimes hard to remember that what you came to do is drain the swamp." It is my opinion that this expression may be applied to the current dilemma of physicians and organized medicine in relation to the problems which are confronting us as we deliver health care as individual practitioners, members of groups, or members of organized local, state or national medical societies.

Given the turmoil within the profession over the last several years, and certainly in Michigan in the last year with the liability insurance problems, I submit that it is time for us to divert our major emphasis from the business of dealing with the alligators and concentrate our greatest efforts to the problem of draining the swamp (that of providing top quality healthy care).

The alligators are easy to identify in the form of the ever-present threat of medical malpractice suits and all of the very emotional reactions that issue has wrought in most of us. Other problems we have dealt with are intervention of third parties into the practice of medicine with prior authorizations, second opinions, and all the other activities which intrude on the day-to-day routine of the physician who is practicing medicine and taking care of patients. The heavy hand of government in the distribution of facilities and technological advances in the form of certificates of need, as well as the federal imposition of prospective payment, have taken up considerable time of the individual physician, the leaders in the health care industry, and our collective physician organizations.

Reflecting on progress

Many of the physicians I have talked to in my travels throughout the Upper Peninsula, as well as other parts of Michigan, have totally dominated the conversation regarding the problems enumerated above. Very seldom have I been in the company of physician groups where we have taken the time to really reflect on the great progress we have made in provision of improved health care which has resulted in the better health of our citizens.

There *has* been significant progress. We have developed the best health care system in the world. We can provide more for a patient than ever before, or than can be provided in other parts of the world. So it costs more to provide these services; should we be diverted from these activities because of the presence of all the alligators in our midst? I submit that we should not. I submit that we should find strength within ourselves as individuals to reflect on all of the positive aspect of being a physician and providing services to our patients, and to rededicate ourselves to that service.

Perhaps it is just my own personal perception, but I suspect that many of us have gotten so busy dealing with the alligators that we have not spent a proper amount of time reflecting on the success which we have had in draining the swamp.

Oops! Here come another alligator! ☐

Doctor Rowe, Hancock public health officer, is a member, MSMS Board of directors and MSMS Committee on Publications.

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ubbard's words uide the rofession

ichigan has long been fornate, and lucky, to have Wilam N. Hubbard, MD, in its rofessional ranks. As Dean of e University of Michigan edical School he contributed uch to maintaining its posion as one of the preeminent edical centers in the nation. s president of the Upjohn ompany, he has provided that ompany with medical expertse which has enabled it to beome a world leader in the harmaceutical industry. uietly, and without fanfare, e has made major contribuons to the profession he cherhes so much; a performance at ranks him with the true pineers in our medical history.

Now, once again, he has ointed the way for us with his emarks on "Trends in Mediine Projected," (reprinted in eptember's *Michigan Mediine*). His words should be reuired reading for all medical ducators, and all the leaders ho are trying to guide our rofession through these turbuent times.

Since his very beginnings, ankind has desired, sought ut, and created a special roup of individuals to be its ealers of the mind and body. oday, with the scientific exlosion that is upon us, that eed is greater than ever beore. And, as always, true healng can be done only when its ractitioners are those special eople who care. Doctor Hubard's remarks point out so eautifully how the hope for ur medical profession lies lmost completely in the ability of our leaders to come to rips with the necessity of elding together the science of medicine with the physician's role as the Samaritan. Any thoughtful person will agree that that is not being done well today.

With government and third party/payors becoming such dominant forces in medical care these days, it is high time for "politics as usual" to be regulated onto a back burner, and for us to return to the vital mission of creating once again what our patients all so desperately want: the caring physician who makes the needs of every patient his/her sole reason for being.

Doctor Hubbard's words clearly point the way.

Brooker L. Masters, MD
Fremont

It's your move

Would you run a business without your input? Would you manage your money without knowing where it is and what it is doing for you? Would you let your personal affairs be controlled by someone else? If the answer is *no*, then why do we tolerate these things when it comes to AMA and our own medical society? AMA and the state and county medical societies have profound affects on our lives, businesses and finances.

Changes in medicine have been rapid in the last six to eight years. Protection of the medical profession from the adverse consequences of these changes is the responsibility of AMA and our medical societies. They usually fare well. But, one major deficiency is the lack of physician participation. (Only about 73 percent of MSMS members are members of AMA.) If physicians want to have any say in the changes facing us, they will have to participate in AMA and medical societies.

Physicians basically are intelligent, hard-working people who do their job with honesty, dignity and pride. But new changes in medical and political environments tell us clearly that this is not enough.

Politics is an integral part of a democratic society and participation is essential for its survival. But in real life nonparticipation is easy. One doesn't have to make any decision so no one is offended. This is a comfort zone or "zero spot."

In the activities of medical societies, members of the "Comfort Zone Society" complain a lot. (That is how you recognize a member of this very large society.) This leaves the decision-making process in the hands of a few active participants only, which really works against a good democratic system.

Our medical societies are run on a democratic system and their real accomplishments depend on the participation of their members. Simply paying dues is never enough. Paying dues makes you a member of the society, not a *participating* member.

If few people participate, there are only a few good ideas and the activity level and responsiveness of the medical society will be below par. Involvement of new blood (it doesn't have to be always *young*) brings new life into the activity and actions of the society. Involvement can mean becoming a delegate, running for an elective office, becoming your hospital HMSS representative, or just sharing your ideas with your representative.

Participation is contagious, believe me. Once involved you love it — it is like a shot of epinephrine in your arm, rather than a kick in the a—. Once you participate, your horizons expand and suddenly you enjoy the same enthusiasm in other activities of life. You even like yourself better.☐

Krishna K. Sawhney, MD
Taylor

The new U-M Hospital

More than a million square feet of medical care

More than a decade of planning and four years of construction reached their culmination this summer with the dedication of the University Hospital and A. Alfred Taubman Health Center.

The new, 586-bed University Hospital began serving patients on February 14, 1986, when 403 patients were moved from 60-year-old former University Hospital. On February 17, the Taubman Center, which houses more than 100 specialty clinics, opened its doors to the first outpatients.

To refer a patient to the new U-M Hospital, call (313) 936-4000.

Construction on the $285 million project began October 15, 1981, when ground was broken for the hospital. Over the next four years, the construction used 10,000 tons of structural steel (enough for 6,060 midsized automobiles) and 1,100,000 bricks (enough to build 27 ranch-style homes).

The new facilities, which are connected by a common main entrance area, total 1.3 million square feet. Inside the buildings, more than four miles of corridors pass by 5,555 doors.

Funding for the project came from several sources, including $33 million in State of Michigan general appropriations and $140 million from a State Building Authority Bond issue. A U-M Hospitals Bond issue raised $93 million, and $20 million is to be raised from private gifts.

The project drew the input of thousands of hospital employees, patients and visitors. Hundreds of employees served as members of planning work groups. More than 3,200 patients and visitors participated the most comprehensive udy ever done to determine eir likes and dislikes in ealth care facilities.

The findings of the Patient nd Visitor Participation oject (PVP) influenced the degn of the new buildings in a umber of areas, including paent room layout, floor numering system, window placeent and courtyard design.

Spaces which would be epeated many times in the ospital, such as patient ooms, were "mocked up" rior to construction and ested for efficiency. Design hanges were made as a result f these efforts.

he future in mind

The new buildings were contructed with the future in ind. A complete level of the ew hospital, for instance, has been set aside for ductwork, wiring, pneumatic tubes and other utilities. As technology changes, presenting the opportunity to upgrade hospital facilities, this level of the building will provide the space for modifications and alterations of utilities with minimal disruption of patient care or structural changes to the building.

Taubman Health Care Center

The A. Alfred Taubman Health Care Center, a 270,000 square-foot ambulatory care facility, opened its doors in February. The four story building houses over 100 specialty clinics and 180 faculty offices.

The University Hospital is directly adjacent to the Taubman Center with easy access to the cafeteria, gift shop and other patient services. The Taubman Center also is connected to the C.S. Mott Children's, Women's, and Holden Perinatal hospitals by an enclosed walkway. While the architectural features of the Taubman Center are striking, the building's function was the primary focus of the architects, staff, planners, and designers. The interior layout is patterned after a private practice model with administrative support areas and physicians' offices adjacent to corresponding clinical areas to enhance patient convenience and staff efficiency.

The central feature of the building is the atrium lobby and waiting area. Light pours into this area from two enormous skylights, each over 100 feet long. The lower floor of the Taubman Center will be home for the Medical Information Center and the Data Systems Center.☐

---

irst impressions and Old Main memories

By John W. Hall, MD

I would walk five floors up and seven floors down in the morning, three floors up and five floors down in the afternoon. But after evening visiting hours were over, I would finally ride the elevators whenever I wanted.

This aerobic exercise program of my own design was my way to avoid spending half of my residency waiting for the elevators at the old University of Michigan hospital. And, although the old metal birdcages have long since been replaced, they represented one small example of the problems of Old Main. And by the time the additions were added, and the replacements were replaced again, a new hospital became the only viable solution to the many problems.

The certificate of need fights, the arguments about the overbedding of the area, and the advantages afforded by state funding now are history. The new University Hospital is in fact open for business.

What's it like?

As a hospital alumnus and a referring physician, I was asked by *Michigan Medicine* to give my impression of this castle set high above the banks of the Huron River. I was part of the Reed Nesbitt Urologic Society group which recently toured the hospital on an alumni weekend.

Doctor Hall

Every physician experiences some nostalgia when reference is made to their training center. The effort we expend in

Continued on next page

Doctor Hall, Petoskey urologist, is a member, MSMS Board of Directors, and is chairman, MSMS Committee on Publicatons. Doctor Hall extends his thanks to John Turck, director, U-M Public and Market Relations, and to Dave Friedo, coordinator of public information.

IMPRESSIONS/Continued

this time of our professional lives really never is matched again. And with that effort comes intense memories and feelings: the highs of a job well done and the lows of a patient's death. The bricks and mortar of this training period play an integral part in the composite of our memories: the hallways filled by the activities of the day, the quiet of the 3 am call to the patient's side, the smell of the lab indelibly etched by the odor of overlooked specimens, the spot of blood on a wall left by some forgotten patient, the taste of the hospital food, that particular room that overwhelms all our senses by the memory of a special patient who touched our heart.

My memories of Old Main Hospital survive. What impressions would the new hospital make?

I would often sit in a nursing station in Old Main Hospital in the quiet of the night and have a recurring fantasy of rolling a bowling ball down that long expanse of linoleum. I would then laugh to myself when I thought of the rude awakening the somnolent nurses would have when it crashed into the opposite end.

What fun I would have at the new University Hospital, where the hallways are longer and straighter than ever. The architects probably would shudder at the thought of the hallways being a measure of their monument, but they serve as a visual reminder of the size and scope of this project. Although there are slightly fewer beds, the building is half again as large as the old hospital.

The attached and complementary new A. Alfred Taubman Health Care Center, as well as Mott Children's and Women's Hospitals, add to the overwhelming feeling of size.

But the building touches our other senses as well. Many of our hospitals, in their pell-mell patterns of growth, have ended presenting a view of a nearby brick wall. The vista from the new hospital overlooking the Huron River Valley is a spectacular and soaring sight. It can't help but lift the spirits of those who struggle within to regain their health.

Soft touches

My dad was a lumber dealer and I inherited his inborn love of the texture and feel of wood. It gives a sense of the living to our sterile, plastic, and stainless steel environment. The architects have made a good effort to use wood, carpeting and plants in an attempt to soften the institutional atmosphere.

However, the intense use the teaching hospital experiences means most of the building materials have to be extremely durable. There already are some scars on the walls and doors, reflecting a wayward cart or shoe. The neutral colors drew some comment in our group as being "too bland," but future plans for additional paintings and works of art should breathe life into this sterile setting.

Any student at University Hospital in the old days will remember teaching rounds in the huge, impersonal wards with their cloth divider curtains. By the time a patient's case was presented to the staff, he had no secrets from his roommates. The new hospital rooms are all private, or semi-private. They are on the small side, but obviously were designed within the cost restraints of the project. They are well thought-out and functional, but leave minimal space for family or visitors.

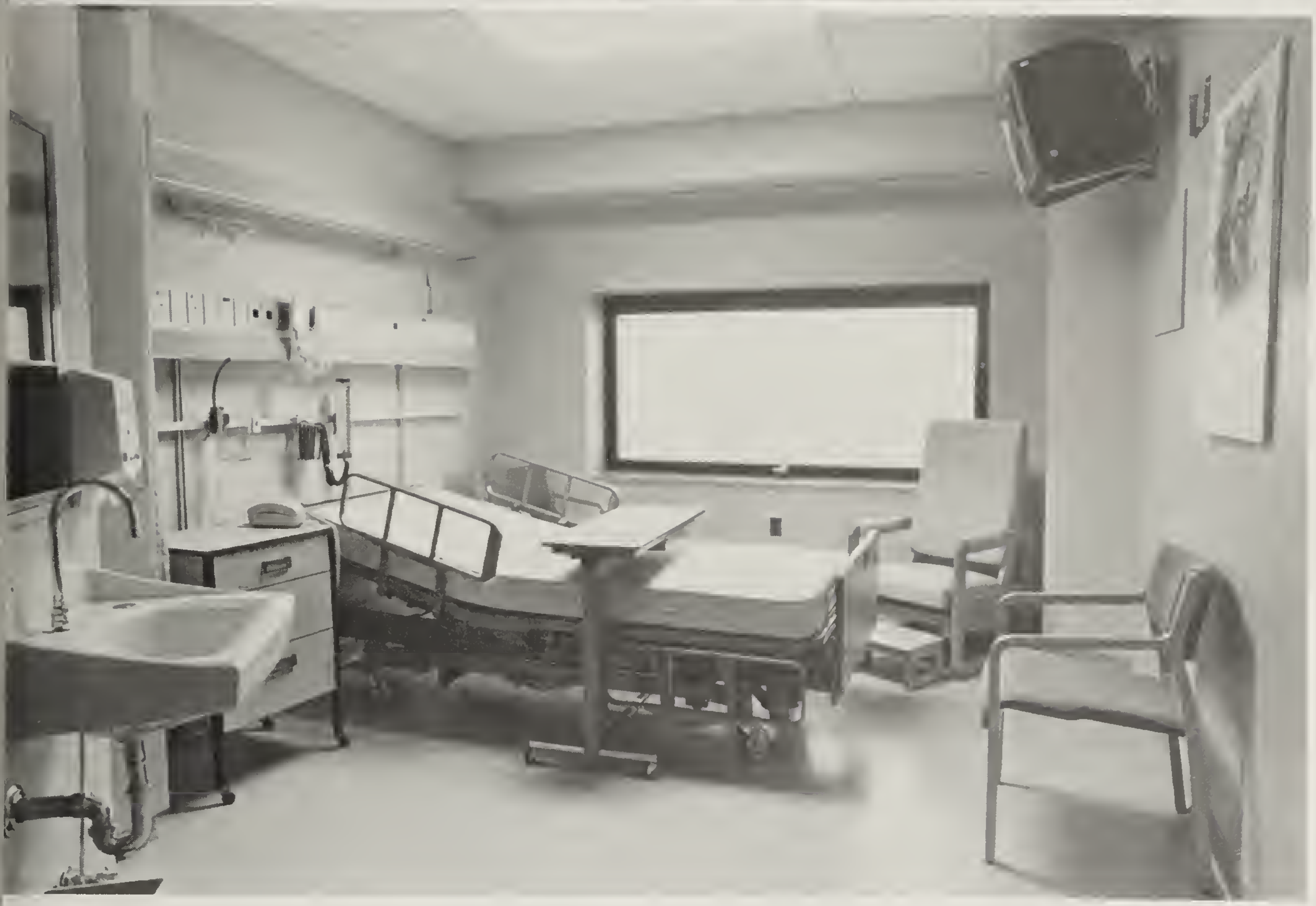
The technology of modern medicine gobbles up most of the increased volume of the building. Scanners and interventional laboratories simply require a lot of space. All of the latest and the best is neatly packaged along patient flow corridors. What I didn't see is any space for next year' advances. My bet is that there will be additions on the drawing board by 1990.

The Taubman Center also represents a major functional improvement for the delivery of outpatient care. The shopping mall concept with the parking lot feeding into waiting areas covered by a huge atrium should be very efficient However, the cost constraints have left the faculty office area extremely compact, with narrow hallways and secretary workstations filling every available square inch. The friction of such close quarters and the lack of any room for expansion reinforces the replacement, rather than expansion, nature of this project.

Roaming robots

No commentary on the hospital would be complete without mentioning the use of robotics. Our tour group stood like kids at a model train exhibit while the fascination with this technology was expressed as smiles on our faces. These electronic R2D2s carry food, pharmaceuticals, laundry and waste carts on pre-programmed routes on the service floors and thus relieve humans of these chores. We watched in amazement while these carts "returned home" and plugged in their electronic umbilical cords to automatically recharge their batteries. "And so, while the robots have replaced humans at work, they have managed to preserve the coffee breaks," said another tour group member.

I was somewhat disappointed by the lack of high tech in the field of patient education. However, the technology is there for the future addition of in-room, televised educational programs. The clutter of forms on the staff room floors and tables is evidence that hard copy still



dominates the patient's chart.

As our tour finished, the comments of the entire group were very favorable. But there was also an expression that the success or failure would rest less with sticks and stones and more with the human beings involved. The entire staff of the new University Hospital has accepted this challenge. They have rededicated themselves to their role as a major teaching and research center, and as a tertiary referral hospital. From administrators and physicians to nurses, secretaries and workers, they all are taking orientation programs, telephone training, and public service seminars so that they might better serve the people of Michigan.☐

Intensive care units

High tech with the human touch

Eighty beds in the new University Hospital are configured in eight 10-bed intensive care units designed for critically ill patients.

State-of-the-art monitoring equipment is standard in the intensive care units, and intensive care patients who need to have their body temperature controlled can be warmed or cooled by a special hypo/hyperthermia system built into the headwall unit. Hoses, through which warm or cool water can be circulated, are connected from the system to a special mattress on the patient's bed.

Many of the intensive care rooms are also equipped with a fully-plumbed toilet that swings out from a cabinet under the sink, providing a welcome alternative to the bedpan for eligible patients.

The semi-circular design of the patient care center allows nursing staff to constantly observe all patients in the unit from a central vantage point.

The intensive care units are assigned to these specialities: Thoracic surgery—10 beds; Neurosurgery—-10 beds; General surgery—20 beds; General medicine—20 beds; Cardiac care—10 beds; Burn care—10 beds.☐

Designing for the health care consumer

From the door captain at the drive-up front entrance to the carefully designed patient rooms, patient and visitor comfort and convenience are emphasized throughout the new University Hospital and A. Alfred Taubman Health Care Center.

A large canopy covers the front entrance for a convenient, weather-protected drop-off. A 1,000 car, covered parking deck next to the entrance is connected to the Taubman Center. Patients and visitors are able to park and enter the facilities without going outside. Valet parking will soon be available.

Lobbies, waiting areas and other public areas are bright and spacious. Artwork and plants are used throughout the buildings to enhance and soften the space. Colors are soft nuetral tones paired with bold classic colors in furnishings and other appointments.

Patient rooms were painstakingly designed with input from architects, planners, designers, staff and patients and visitors. For example, windows are large and placed lower than usual to allow the patient to enjoy the view from bed. All patient rooms are private or semi-private rooms and each is equipped with a fully handicapped-accessible bathroom with shower.

These features are results of

The spectacular 55-foot vaulted glass atrium lobby offers a gracious welcome.

"Patient and Visitor articipation Project" (PVP), e first comprehensive study ver done in a hospital setting f patient and visitor likes and islikes about health care cilities.

The team of project searchers systematically athered information from atients and visitors about eir hospital design-related eeds and preferences, then orked to implement as many f these findings as possible.

Between 1980 and 1985, the VP Project involved more than ,200 patients and visitors in 3 separate studies, ranging rom the design of patient ooms to the placement of igns in the corridors. Some of he changes which have been dopted include the design or lacement of:

- windows in waiting rooms
- low placement of windows n patient rooms
- bench design and seating onfiguration in the outdoor ourtyard
- access route to front ntrance and entrance to the arking deck
- floor numbering system
- design of hospital gown
- location and design of losets and bathrooms in atient rooms
- bathrooms and telephones near visitor lounges
- design and placement of signs
- design of handrails
- roving art cart program☐

Robots deliver supplies

The new University Hospital employs a new breed of hospital helper. A computerized material handling system with fifteen robocarriers serves every floor in the new hospital and has access to four of the adjacent facilities.

Carrying specially designed carts that hold as much as 500 pounds of bulk materials such as linens, medical-surgical supplies and food, these "electronic mules" complete 500-700 tasks each day. One of these tasks, for example, is to collect from throughout the building the seven tons of trash the hospital produces each day.

Unglamorous by any standards, the robocarriers are stainless steel carts almost seven feet long, four feet wide and two feet high. Sensors on the underside of each carrier will follow a cabled path buried in the floor. The carriers travel horizontally only on the B2 level, the lowest floor in the building, which is primarily a service floor.

The robocarriers have dedicated elevators and holding rooms on each floor of the building, one on either end. They do not travel on any of the public pathways and are not seen by patients and visitors.

Similar automated systems are in use at two hospitals in Europe, but the University of Michigan Hospitals is first to use a system this sophisticated in the United States. Such robots have been used extensively in industry where they move supplies in vast warehouses.☐

Patient-to-nurse communications

The nurse call system on the inpatient floors is one of several advanced communications systems in the new University Hospital and has several significant features:

- The majority of calls are routed through the patient care center to determine the most appropriate response to the call. When a nurse is required, the receiving staff person transfers the message to the patient's nurse via a digital beeper. Noiseless, vibrating beepers are available for use in the evening hours.
- The nurse call system is connected to the radio paging system. Because of a linkage between these systems, staff members in the patient care center can page a nurse through radio paging regardless of the nurse's location on the floor. The use of these radio pagers eliminates the need to physically locate a nurse.

This linkage also allows the nurse the option of bypassing the patient care center and establishing a direct link with the patient's call.

- Code blue (which signals cardiac or respiratory arrest) on the acute care units will activate alarms in the patient care center, satellite stations, staff stations and duty stations A special light path using zone lights will turn on and guide staff to the code blue area. A status light will flash above the room where the arrest is occuring.
- Code blue on the intensive care units is a separate, fully monitored system which automatically notifies the patient care center, security and paging system (a group page is sent out to all members of the code blue/arrest team). Zone lights create a light path to direct the staff from elevators to the proper patient room.☐

laternal and child health enter in the works

The University of Michigan Medical Center has sub-itted an application to the lichigan Department of Public ealth for a certificate of need o develop a Maternal and hild Health Care Center.

The Maternal and Child lealth Care Center would cen-ralize through renovation and ew construction the U-M Med-cal Center's major programs in bstetrics, pediatric medical nd surgical services, outpa-ient gynecology and child and dolescent psychiatry.

Estimated to cost $46 mil-ion, the Maternal and Child lealth Care Center would be ocated just south of University lospital. It would comprise the .S. Mott Children's, Women's nd Holden hospitals complex, n addition to the A. Alfred aubman Health Care Center nd an addition to the Mott/Women's/Holden complex or both support services and ew space for replacement eds. Less than half the current umber of beds would be eplaced.

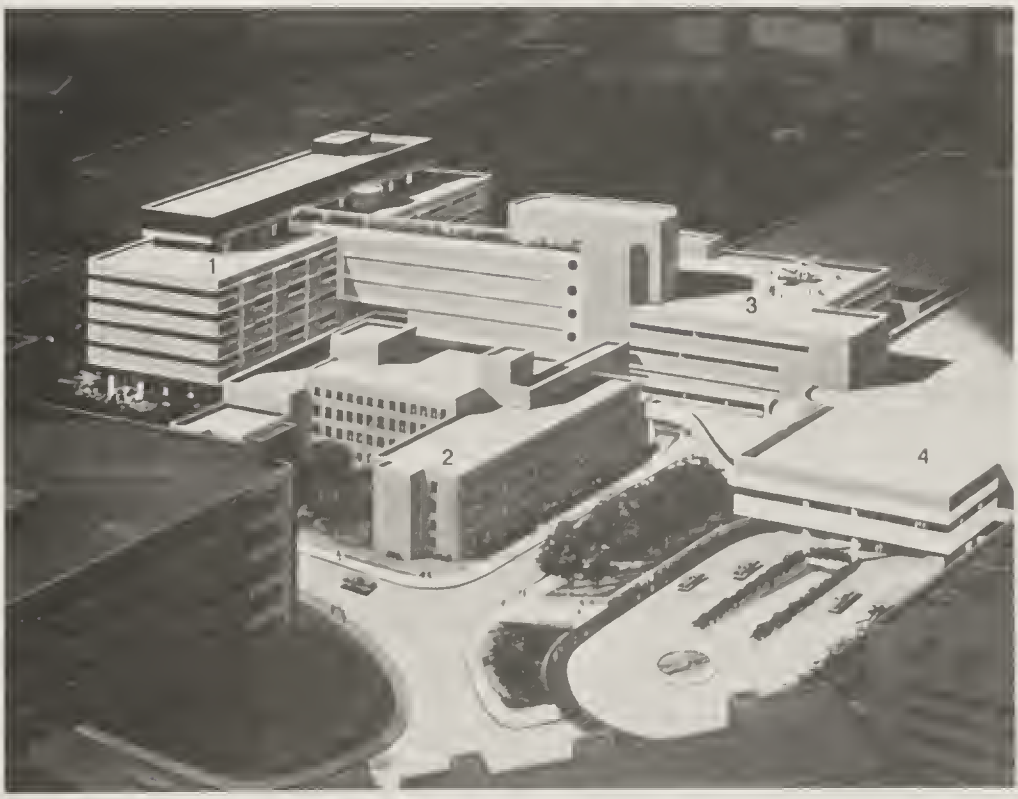
The project would be paid for by U-M Hospitals' reserves. According to John D. Forsyth, executive director of U-M Hospitals, "Consolidating and modernizing our facilities in maternal child health care is very much needed. The Maternal and Child Health Care Center will address current health care treatment needs and enable us to enhance studies of medical, nursing and other professional issues relating to health care for women and to the physical and mental health care problems of children and adolescents.

"The integration of these facilities will improve operating efficiencies and reduce the hospitals' bed complement from 888 to 884."

Approximately $15.6 million of construction costs for the proposed Center were included in the certificate of need (CON) for the $285 million Replacement Hospital Program (RHP). The Medical Center is seeking a new CON for the Maternal and Child Health Care Center and a reduction of the original RHP CON.

Key elements of the Maternal and Child Health Care Center are:

Continued on next page



The proposed Maternal and Child Health Care Center would include: (1) Mott Children's Hospital with new women's inpatient beds; (2) Faculty offices; (3) Expansion to Mott, Women's and Holden Hospitals including beds for child and adolescent psychiatry; (4) Expansion to the A. Alfred Taubman Health Care Center for maternal and child health outpatient facilities.

MATERNAL/Continued

- New construction adjacent to Mott, Women's and Holden hospitals for expansion of support space and reallocation of beds;
- Expansion of Taubman Center southward, to accomodate pediatrics, obstetrics and child and adolescent outpatient services;
- Conversion of Women's Hospital into offices;
- Conversion of one floor of Mott to obstetrical beds;
- Moving of the child and adolescent psychiatric inpatient and outpatient programs into the proposed center from the Child and Adolescent Psychiatric Hospital;
- Increasing the number of pediatric and neonatal intensive care beds through reallocation of acute care beds.

State of the art care

The benefits of the Maternal and Child Health Care Center would include, Forsyth said, state-of-the-art care for mothers and children in Michigan, enhanced research capabilities, increased opportunities for multidisciplinary training and improved access to outpatient and intensive care services.

Current facilities are deficient in several respects, according to Forsyth:

- Hospital and the Child and Adolescent Psychiatric Hospital cannot be brought up to code for inpatient care for programs now envisioned without incurring inordinate costs.
- Demand for pediatric and neonatal intensive care has been consistently high. More intensive care beds in these areas are needed to meet the increased demand.
- The mode of treatment in child and adolescent psychiatry has been shifting to new forms that require more medical and support services and less time in the hospital. Renovation is needed to accommodate these new treatment methods.☐

U-M Hospital vital statistics

Gross Square Footage: 1,000,000 sq. ft.
Site: North of A. Alfred Taubman Health Care Center, facing Huro
River Valley and Fuller Road.

Contents:

1. Adult medical, surgical, and psychiatric inpatient units (586 bed
2. Diagnostic and treatment areas
3. Emergency Rooms: Adult walk-in, Pediatric walk-in, Psychiatri Emergency
4. Cafeteria, Gift Shop, Chapel, Patient Library, Barber and Beaut Shops, Amphitheater and other classroom facilities

Linked to:

1. A. Alfred Taubman Health Care Center and Patient/Visitor Parking Deck (attached)
2. Towsley Center for Continuing Medical Education (by bridge) an C.S. Mott Children's Hospital (by bridge)
3. Former Outpatient Building (by bridge)

Number of Floors: 11

Capital budget: $210 million

Architect: Albert Kahn Associates, Inc., Detroit

U-M Hospital statistics

Bed capacity after move into new University Hospital:

C.S. Mott Children's Hospital	188 beds
Women's Hospital	32 beds
Child and Adolescent Psychiatric Hospital	34 beds
*Kellogg Eye Center	32 beds
*New University Hospital	
beds in single rooms	232 beds
beds in double rooms	232 beds
intensive care	70 beds
adult psychiatric	52 beds
*New Burn Center (includes 10 ICU beds)	16 beds
Total — All Hospitals	888 beds

(*New construction)

Total licensed bed capacity by function:

Adult Medical-Surgical	582 beds
Pediatrics	188 beds
Obstetrics	32 beds
Psychiatric	86 beds
Total	888 beds

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MSMS to educate MDs about AIDS

Frederick W. Bryant, MD, Royal Oak is chairman of the statewide AIDS Provider Education Task Force. The first meeting was convened October 8 at MSMS headquarters.

Photos by Pattrick Yocke

The Michigan Department of Public Health, in response to the growing AIDS problem, issued a $250,000 contract to MSMS to develop a provider education plan. The first meeting, above, was attended by representatives of forty-five statewide groups of health professionals and facilities.

MDPH Director Gloria Smith, PhD, told media representatives and meeting attendees that Michigan is 18th among the states in total number of AIDS cases to date.

James T. Harrison, MD, left, is MDPH chief medical executive. Thomas R. Berglund, MD, right, MSMS president said, "The investment of state funds into the education of professionals means all of us can join in these efforts. We need to earn the public's confidence and respect now, to transfer our information into practice."

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Dimension III for doctors:
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Dimension III for employees:
Deductible — $250 one person
$500 family

Once the deductible amount has been met, Dimension III pays 80% and the subscriber pays a 20% copayment for covered health care services. When the subscriber has paid $1,000 in copayments, no further copayments are required. Dimension III pays 100% up to $1 million. And when you select one of these plans, you'll get all the benefits that characterize the best health care coverage available:

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- ☐ Outpatient care benefits.
- ☐ Psychiatric care benefits.
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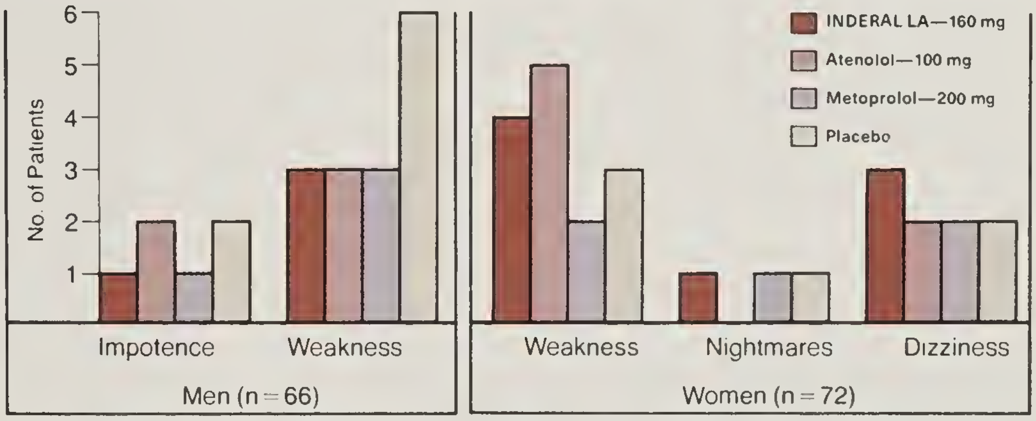

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Please turn page for brief summary of prescribing information

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INDERAL® LA

(PROPRANOLOL HCl)

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INDERAL LA and INDERIDE LA Capsules should not be considered simple mg-for-mg substitutes for INDERAL and INDERIDE Tablets Please see package circulars

CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL® LA): Propranolol is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs

WARNINGS

Propranolol hydrochloride (INDERAL® LA): CARDIAC FAILURE Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or propranolol should be discontinued (gradually, if possible)

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction following *abrupt* discontinuance of propranolol therapy Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hyperthyroidism Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm Propranolol does not distort thyroid function tests

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker In one case this resulted after an initial dose of 5 mg propranolol

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS INDERAL should be administered with caution, since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes In these patients, it may be more difficult to adjust the dosage of insulin Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease In patients with renal disease, thiazides may precipitate azotemia In patients with impaired renal function, cumulative effects of the drug may develop

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma

Thiazides may add to or potentiate the action of other antihypertensive drugs Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported

PRECAUTIONS

Propranolol hydrochloride (INDERAL® LA): GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function Propranolol is not indicated for the treatment of hypertensive emergencies

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test Withdrawal may lead to a return of increased intraocular pressure

CLINICAL LABORATORY TESTS Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs, such as reserpine, should be closely observed if propranolol is administered The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY Long-term studie in animals have been conducted to evaluate toxic effects and carcinogenic potential In 1 month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was n evidence of significant drug-induced toxicity There were no drug-related tumorigeni effects at any of the dosage levels Reproductive studies in animals did not show an impairment of fertility that was attributable to the drug

PREGNANCY Pregnancy Category C. Propranolol has been shown to be embryotox in animal studies at doses about 10 times greater than the maximal recommended huma dose. There are no adequate and well-controlled studies in pregnant women Propranol should be used during pregnancy only if the potential benefit justifies the potential risk t the fetus.

NURSING MOTHERS Propranolol is excreted in human milk Caution should be exe cised when propranolol is administered to a nursing mother

PEDIATRIC USE Safety and effectiveness in children have not been established

Hydrochlorothiazide: GENERAL Periodic determination of serum electrolytes t detect possible electrolyte imbalance should be performed at appropriate intervals

All patients receiving thiazide therapy should be observed for clinical signs of fluid c electrolyte imbalance, namely Hyponatremia, hypochloremic alkalosis, and hypokale mia. Serum and urine electrolyte determinations are particularly important when th patient is vomiting excessively or receiving parenteral fluids Medication such as digital may also influence serum electrolytes Warning signs irrespective of cause are Dryness c mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps muscular fatigue, hypotension, oliguria, tachycardia and gastrointestinal disturbance such as nausea and vomiting

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis i present, or during concomitant use of corticosteroids or ACTH

Interference with adequate oral electrolyte intake will also contribute to hypokalemia Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect o digitalis (eg, increased ventricular irritability) Hypokalemia may be avoided or treated b use of potassium supplements, such as foods with a high potassium content

Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver or renal disease). Dilutional hypona tremia may occur in edematous patients in hot weather, appropriate therapy is wate restriction, rather than administration of salt, except in rare instances when the hyponatre mia is life-threatening In actual salt depletion, appropriate replacement is the therap of choice

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy

Insulin requirements in diabetic patients may be increased, decreased, or unchanged Diabetes mellitus which has been latent may become manifest during thiazide administration

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy

Thiazides may decrease serum PBI levels without signs of thyroid disturbance

Calcium excretion is decreased by thiazides Pathologic changes in the parathyroi gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS Thiazide drugs may increase the responsiveness t tubocurarine

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient Thiazides may decrease arterial responsiveness to norepinephrine This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use

PREGNANCY Pregnancy Category C Thiazides cross the placental barrier and appear in cord blood The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult

NURSING MOTHERS Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing

PEDIATRIC USE Safety and effectiveness in children have not been established

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL® LA): Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy

Cardiovascular Bradycardia, congestive heart failure, intensification of AV block, hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type

Central Nervous System Lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place; short-term memory loss, emotional lability; slightly clouded sensorium, and decreased performance on neuropsychometrics

Gastrointestinal Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation; mesenteric arterial thrombosis, ischemic colitis

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory Bronchospasm

Hematologic. Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune In extremely rare instances, systemic lupus erythematosus has been reported

Miscellaneous Alopecia, LE-like reactions, psoriasiform rashes, dry eyes; male impotence, and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol

Hydrochlorothiazide:

Gastrointestinal Anorexia, gastric irritation, nausea, vomiting cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis

Central Nervous System Dizziness, vertigo; paresthesias; headache, xanthopsia

Hematologic Leukopenia, agranulocytosis; thrombocytopenia, aplastic anemia

Cardiovascular Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics)

Hypersensitivity Purpura, photosensitivity; rash; urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis), fever; respiratory distress, including pneumonitis; anaphylactic reactions

Other Hyperglycemia, glycosuria hyperuricemia, muscle spasm; weakness, restlessness, transient blurred vision

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn

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REFERENCE:

1. Ravid M, Lang R, Jutrin I The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily *Arch Intern Med* 1985,145 1321–1323

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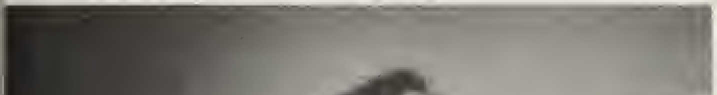
ichard Gascoigne, MD, Adrian, chairman of the 1986
ublic Affairs Leadership Conference, left, accepted the
ey to the city from Lansing Mayor Terry McKane.
layor McKane welcomed more than 200 attendees to
ne October 15 conference held at the Clarion Hotel.

Forward-thinking physicians gain insight at MSMS Public Affairs Leadership Conference

Attentive physicians heard from sixteen speakers. The day-long program featured these presentations: Michigan toward the year 2000; Michigan political trends; Pricing human life — Ethical issues in an era of cost containment; Doctors, hospitals and the new health care — A joint adventure; Professional liability — Phase II; and The social and political impact of AIDS and drugs in Michigan.



eonard M. Fleck, PhD, of MSU's Medical Humanities
rogram, spoke to the key dilemma faced by physicians
n this era of cost containment: How can a good physi-
ian — an uncompromised advocate for patients — par-
icipate in any sort of rationing scheme that will deny
otentially effective medical therapy to patients?

More photos on next page

Gerald A. Faverman, PhD, chairman of Public Sector Consultants, described his vision of Michigan's health care environment in the year 2000.

Spencer Johnson, president, Michigan Hospital Association, talked about "the new health care," myths about it and specific issues affecting providers, the quality of health care, MSMS and MHA.

Many conference-goers, including B. David Wilson, MD, above, took the opportunity to question the speakers.

Gerald H. Mandell, MD, member of the MSMS board of directors, heads up the medical society's risk management initiatives. He shared revealing statistics with the audience and fielded questions.

Evelyn J. Fisher, MD, infectious diseases expert, updated attendees on the growing AIDS problem in Michigan. She stressed that education is the key to AIDS prevention and to defusion of public hysteria.

A distinguished panel addressed Professional Liability — Phase II. Special guest C. John Tupper, MD, AMA trustee, far left in glasses, shared a national perspective on the problem. Frederick V. Minkow, MD, second from left, outlined upcoming legislative initiatives. W. Peter McCabe, MD, second from right, discussed alternatives to the tort reform system, and Gerald H. Mandell, MD, far right, emphasized risk management.

Photos by Pattrick Yockey

By James G. O'Brien, MD

Elder abuse and the physician

O'Brien

While the 60s were identified as the decade for the discovery of child abuse, the 70s witnessed public awareness of spouse abuse. Now the 80s are predicted to be the decade for the coming of age of elder abuse.

It has been estimated that somewhere between four percent and 10 percent of the elderly in the community are victims of abuse (Block & Sinnott, 1979; Lau and Kosberg, 1979). Some indicators point to the likelihood that abuse will increase in the future as a result of an increasing number of elderly, frail individuals, in need of supportive services, particularly from family members. This problem is compounded by smaller family size and therefore a decreasing number of family members to share in this support. It is surprising to discover that most abusers of older persons are members of the victim's own family (O'Malley, 1982; Sengstock, 1982).

Elder abuse is not new, as there is evidence from antiquity that elders have been abused. What is new is the study of this phenomenon. It is thought that only one in six cases comes to the attention of authorities so it is probable that only the tip of the iceberg is seen when abuse is identified.

Limited information

The studies thus far have provided very limited information because there is no standard definition of abuse and because nonprofessionals are frequent sources of information. In addition, most of these studies have been retrospective and dependent on the recall of the individuals being surveyed. Most individuals

Continued on page 620

Doctor O'Brien is associate chairman and professor of the Department of Family Practice and director of geriatrics for the College of Human Medicine, Michigan State University. He is a member of the MSMS Committee on Aging.

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The abuser usually lives with the victim, typically is related and in fact may be the caregiver.

ABUSE/Continued

agree that a definition of elder abuse should include some of the following elements: physical, psychological and material abuse, exploitation and neglect.

The causes of abuse are multiple and include learned violence where individuals reared in a violent environment later use violence when frustrated or stressed. Children who are victims of abuse may now engage in reverse violence and abuse their parents. Many cases of abuse result when caregivers are overwhelmed by the needs of the dependent parent. The typical victim is female, older than 75 and dependent in some way. Individuals who are mentally impaired appear to be at higher risk and this phenomenon crosses all socioeconomic and educational boundaries.

Physician involvement

Physicians, according to Kosberg, are in strategic positions to identify elder persons who are victimized by abusive behavior of others. Despite this fact, physicians have figured in a very limited way in elder abuse research thus far.

In 1984 with colleagues from North Carolina, I conducted a survey of 3,001 primary care physicians and nurse practitioners in Michigan and North Carolina and yielded the following information: 27.9 percent of physicians had encountered a case of abuse with an additional 20.7 percent having suspected but not confirmed a case. Neglect was identified as the most frequent type of abuse encountered followed by psychological, physical abuse and abandonment. In the vast majority of instances, the reason given for the medical visit was not related to abuse, which suggests a much more active role for the physician in the detection of abuse. Most physicians felt abuse was difficult or very difficult to detect.

When the physician confronted the abused individual the most frequent response was denial. Despite the fact that Michigan and North Carolina have mandatory reporting laws for elder abuse (in Michigan physicians can decide not to report abuse if this is the best interest of the victim) over 70 percent of physicians in both states were unaware of the reporting law and its requirements which certainly points out a need for further education in this area.

A positive feature of this survey was that over 60 percent of physicians expressed a willingness to become involved in abuse cases beyond medical management. This type of intervention maybe the most acceptable and least threatening to families.

This study demonstrated that elder abuse is a significant problem for physicians in our state. Elder abuse is not well understood, and state laws are not well known by physicians who often lack the resources to deal with the problem of elder abuse. It is heartening that a significant portion of physicians are willing to become involved in the resolution of this problem and contribute new knowledge in this area. Understanding and defining this problem is likely to lead to the development of programs in prevention and intervention that are effective.☐

Editor's Note: The AMA Council on Scientific Affairs considered the issue of elder abuse during the AMA Annual meeting in June. To obtain a copy of its report, *Report J-Elder Abuse and Neglect*, contact Joyce Crum, MSMS, 120 W. Saginaw, PO Box 950, East Lansing, MI 48823.

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By Thomas J. DeKornfeld, MD

Unrenewed licenses become null and void

DeKornfeld

It is that time of year again when one third of the physicians licensed in Michigan will be mailed their license renewal application. It seems, therefore, to be appropriate to devote this column to the legalities surrounding the license renewal process and to some of the problems this process causes both to the practitioner and to the Bureau of Health Services in the Department of Licensing and Regulation.

The statutory basis for renewal is contained in the Public Health Code, Act 368 of 1978, as amended in July, 1986. The appropriate section (16201) reads :

"(1) A license or registration shall be renewed by the licensee or registrant on or before the expiration date as prescribed by rule. The department shall mail a notice to the licensee or registrant at the last known address on file with the board, advising of the time, procedure and fee for renewal.

"(2) A license or registration not renewed by the expiration date may be renewed within 60 days of the expiration date upon application, payment of renewal and delinquent fees, and fulfillment of any continued competency or continuing education requirements set forth in this article or rules promulgated under this article. The licensee or registrant may continue to practice and use the title during the 60-day time period.

"(3) If a license or registration is not renewed within 60 days of the expiration date pursuant to subsection (2), the license shall be considered null and void. The licensee shall not practice or use the title and a registrant shall not use the title. Except as otherwise provided by rule the license and registration may be reinstated within three years of the expiration date upon application, payment of renewal and delinquent fees and fulfillment of any continued competency or continuing education requirements in effect at the time of the expiration date, or which would have been required had the individual renewed his or her license pursuant to subsection (1). A temporary license may be issued under section 16181 pending the results of action taken under this subsection."

The section goes on to address the problems of reinstatement after a period of three years and, further, that the board can take disciplinary action against a licensee even though the license had expired. These latter two matters may be the subject of a future column.

What then does license renewal mean from a practical point of view? The Bureau will mail out about 7,000 renewal applications on or about December 1, 1986. The renewal

Continued on page 627

Doctor DeKornfeld is administrator, Michigan Board of Medicine.

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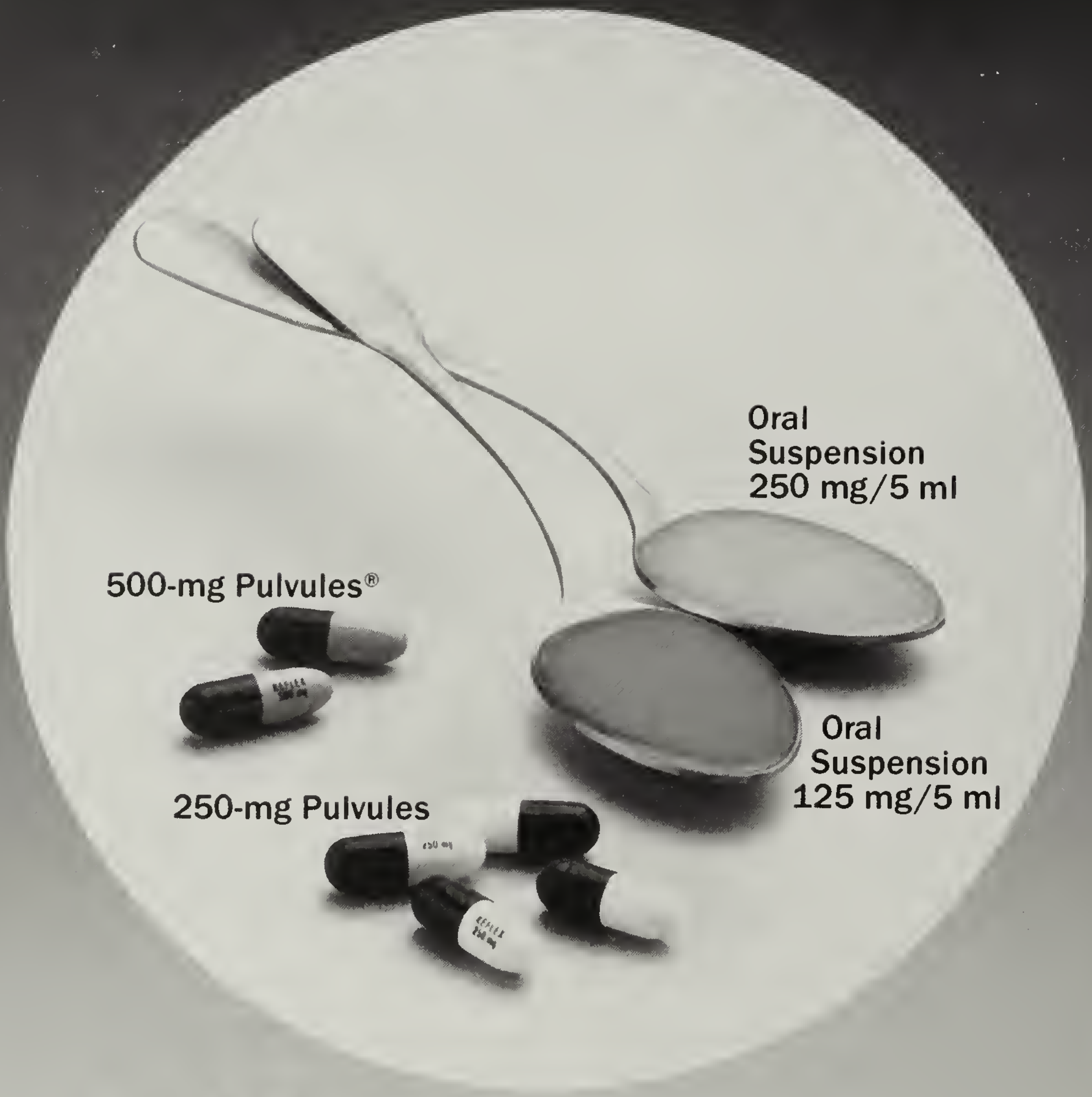

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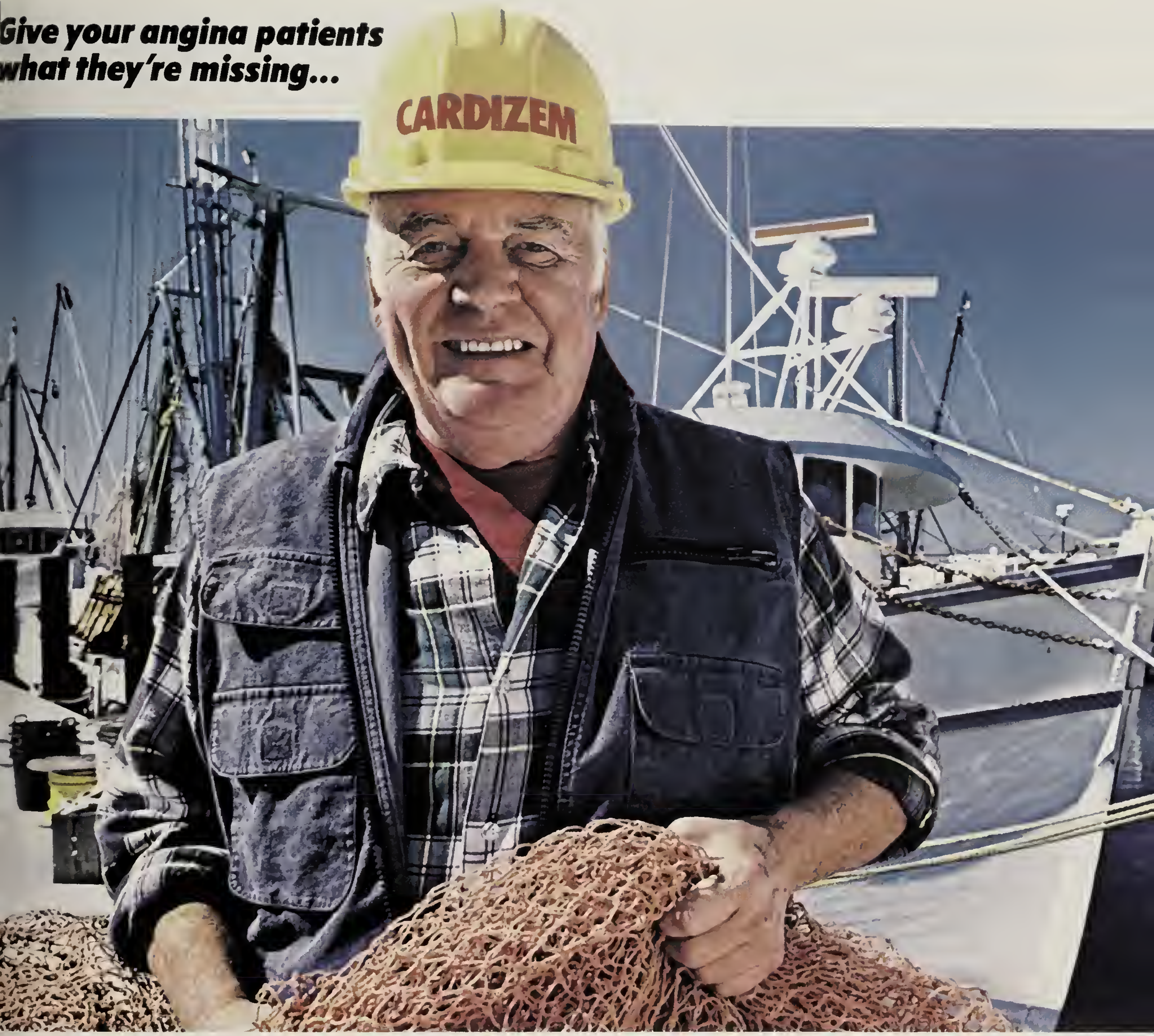

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*****See Warnings and Precautions.***

Please see brief summary of prescribing information on the next page.

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Brief Summary
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CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).
Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women, therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.
Nervous System:	Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.
Gastrointestinal:	Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.
Dermatologic:	Petechiae, pruritus, photosensitivity, urticaria.
Other:	Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. Issued 11/85

See complete Professional Use Information before prescribing.

References: 1. Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers: Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983; 106(6):1341-1347. **2.** Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984;24(Dec):150-159. **3.** Johnston DL, Lesoway R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985;55:680-687. **4.** Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39. **5.** Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982;50(Sept):94-116.

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orm indicates the expiration date, the renewal fee, the late ee and the expiration date of he renewed license. The back f the form has some spaces o be filled in with some items f information and, very importantly, a signature line. By igning this line you attest that ou have completed the coninuing education requirements ecessary for the renewal of he license. This item, continung education, is becoming inreasingly more important and robably will be the subject of nother column.

As stated above, the Bureau will mail out about 7,000 renewal applications to the ast and best address that we have, in the hope that we will eceive, by the end of the year, about 7,000 returns. Like most pious hopes, this one also is doomed to disappointment. Some of you have died, some of you have retired and many of you have moved without without letting us have he benefit of your new address, which incidentally, is a violation of Section 16221 (f) of the Code and may be punishable by a reprimand or fine.

About 10 percent of the renewal applications will be returned to us by the Postal Service marked "undeliverable." In the past the Bureau had to send out a second notice, as required by law, to the same address, which to nobody's great surprise was also returned as "undeliverable." The July, 1986 amendment to the Code no longer requires this peculiar and expensive exercise in futility.

Null and void

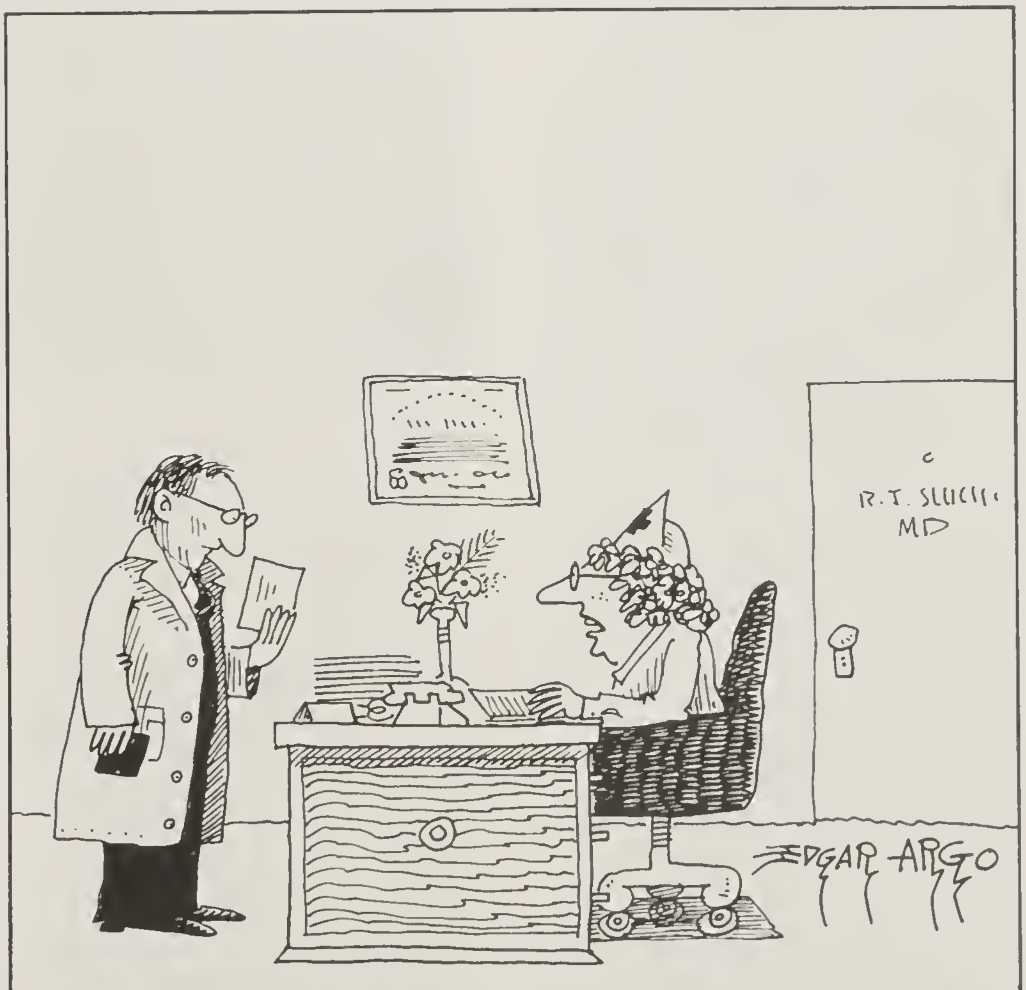
This year only one notice will be sent, and if you don't get it, for whatever reason, and don't renew your license, the license will automatically and without any further ado become null and void at midnight on March 31, 1987. Starting on April 1, 1987 you will no longer be a doctor in the eyes of the state. If you continue to practice, you practice without a license and you are in violation not only of the Health Code but may also be liable to criminal prosecution.

In order to avoid all these unpleasantnesses, may I urge you most earnestly to ask yourself the following three things:

1. If you have changed your address during the last three years, have you notified the Board of Medicine of your new address?
2. Have you taken a solemn vow to return the renewal application the day you receive it?
3. Have you instructed your receptionist, office staff, secretary, significant other, or whoever opens your mail to bring the renewal notice to your immediate attention?

If the answer to any of the above is no, please take the appropriate remedial steps immediately. To renew your license is your responsibility and yours alone. Please don't jeopardize your practice and your patients' continued care by ignoring these simple rules. For those of you in a group practice, may I suggest that you instruct your office manager to keep track of the expiration dates of the licenses of the members of your group. Should any of them not receive their renewal notice by the end of December, please contact the Board of Medicine immediately. Let us know about it, and we will check our address file and send you an application right away. The last thing we want to do is start disciplinary action against you for failure to renew your license.

In this era of preventive medicine I can't think of a better method of preventing serious emotional trauma than by keeping your license active.☐



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By Robert M. Leitch, M

In memoriam

Vernon V. Bass, MD 1917-1986

With the passing of Vernon V. Bass, MD, organized medicine in the State of Michigan has lost a beloved and valuable member.

Following graduation from the University of Wisconsin Medical School in 1950 and residency training in obstetrics and gynecology, Doctor Bass came to Saginaw where he had practiced obstetrics and gynecology since 1952. In addition to being a leader in his local community in clinical ob/gyn, Doctor Bass has been active on a number of other fronts.

Doctor Bass

Vern was active in local and state politics. He was one of the founders and a former chairman of MDPAC, following which he served as its secretary for many several years. He was also active in medical politics serving as alternate delegate and delegate to MSMS from Saginaw County Medical Society. He served as Speaker of the House of Delegates for six years, from 1971-76. He was President of MSMS from 1976 to 1977. He also was a member of the Michigan Delegation to the American Medical Association House of Delegates during the 1970s.

Vern was one of the founders of the Michigan Physicians Mutual Liability Company (MPMLC) in 1975 and became its first president in 1976, serving for four years until 1980. He continued on the board of directors of MPMLC since that time and served as chairman of the Finance and Investment Committee and as a member of other committees.

His many activities also included the Saginaw Chamber of Commerce. In addition, Vern found time for several hobbies. He was actively engaged in farming for several years and was a well known breeder of Charolais cattle, serving as a member of the American-International Charolais Association, the Ohio Valley Charolais Association and the board of the Michigan Charolais Breeders Association.

Vern also enjoyed boating and flying. One of his real loves outside of his practice was the game of bridge. During many a spare hour he could be found at the Saginaw Club playing bridge with some of his close friends and his hearty laugh frequently could be heard throughout.

Vern had an active and innovative mind. He became interested in computers early in their development and enjoyed activities relative to his home personal computer.

All of us at MSMS and MPMLC will sorely miss the strong leadership and wise counsel which Vern provided us. We extend our deepest sympathy to his wife Jean, his daughter Jill and son John and join them in their grief at the loss of this beloved colleague. ☐

Doctor Leitch, Battle Creek, is president of Michigan Physicians Mutual Liability Company, a member, MSMS Board of Directors, and is a past president of MSMS.

By Frank B. Walker, MD

In memoriam

Donald N. Sweeny, Jr., MD
1916-1986

Donald N. Sweeny, Jr., MD, a physician and surgeon from Grosse Pointe, highly respected and acknowledged for his many contributions to both medical and civic organizations at local, state and national levels, died September 9, 1986 after a long battle with cancer.

After graduation from the University of Michigan in 1936 (Phi Beta Kappa and Phi Eta Sigma) and Harvard Medical School in 1940 (Alpha Omega Alpha), Doctor Sweeny was an intern and surgical resident at Massachusetts General Hospital from 1940-44. Following service in France and Germany with the US Army Medical Corps, he returned to his native Detroit in 1947 and entered the private practice of general surgery until his retirement in the spring of 1986.

Doctor Sweeny was certified by the American Board of Surgery in 1949, and was a Fellow of the American College of Surgeons and the International College of Surgeons. He was a member and past-president of both the Detroit Academy of Surgery and the Detroit Surgical Society.

Doctor Sweeney

Despite an extremely busy surgery practice and administrative responsibility at Riverside Clinic in Detroit, he found time to become involved in a wide variety of "extracurricular" medical endeavors. To catalog only some of these interests gives some indication of the wisdom, vision, and breath and depth of involvement of Doctor Sweeny:

Wayne County Medical Society: Delegate to MSMS, member of WCMS Council, member and chairman of the WCMS Board of Trustees, WCMS secretary, member and chairman of the Ethics Committee, editor and associate editor of the *Detroit Medical News;*

Michigan State Medical Society: Councilor (Director) from Wayne County, member and chairman of multiple MSMS reference committees, member ad hoc Committee on Malpractice, founding member and chairman of MSMS Judicial Commission;

American Medical Association: Delegate from MSMS (1962-1986) and past chairman of Michigan delegation to AMA, member and chairman of multiple AMA reference committees, member (1970-79) and chairman (1977-78) of AMA Council on Medical Service, member of initial AMA Council on Long Range Planning and Development, member of committee to form an AMA Department of Religion and Medicine.

Other medical activities include the Michigan Physicians Mutual Liability Company (incorporator and member, Board of Directors), member of the Michigan Board of Medicine (1976-77), and Michigan Medical Service (Blue Shield) Board of Directors (1958-72) and vice-president (1962-72).

However, the above recitation of accomplishments represents only those activities of Doctor Sweeny pertaining to the medical profession. In addition, he was long active and interested in a wide variety of civic and social endeavors. He was on the board of directors of Civic Searchlight, Inc., a nonpartisan organization involved in examining the credentials of candidates for political office.

Doctor Sweeny's beloved wife and companion, Mary Margaret, preceded him in death by less than six months. Survivors include his son, Donald, III, and three daughters, Sharon, Sheila and Sara.

All who knew Don were touched by his knowledge, enthusiasm and compassion. He was always prepared, extremely articulate, and consistently forceful and decisive. Our sympathy is extended to his family, friends, patients and colleagues. We all shall miss him.☐

Doctor Walker, Grosse Pte. Farms, is a member, MSMS Board of Directors, and was among Doctor Sweeny's many close physician friends.

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3

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Sign all entries.

Initial and date all notes you make in a patient's chart to show the treatment you provided chronologically.

Document all telephone calls.

Write down instructions, orders and prescriptions you give over the phone — in the office and at home. Keep a notepad and pen close by for documenting calls. Your office personnel also should note their phone conversations with patients.

Acknowledge all diagnostic reports.

Confirm your review of diagnostic reports by initialing and dating them before filing in the patient record.

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By Sharon L. Olson, RN, M

The Michigan model: A year review of hospice licensure

Hospice licensure became effective in Michigan in October, 1984. The following article is a review of the first year of licensure and a forecast of future hospice trends in Michigan.

Ms. Olson is hospice coordinator, Michigan Department of Public Health.

On October 8, 1979, Rep. David Hollister (D-Lansing) acted as chairman for the first meeting of a hospice work group which he had solicited. Twenty-three persons were present representing various state agencies and private groups. The subject for discussion was the recently introduced House Bill 2909, which by intent would serve to define hospices in Michigan. This preliminary meeting and many subsequent ones provided the foundation and support for Part 214 of the Michigan Public Health Code (Act 368 of 1978 and amended) which created the statutory base for hospice care in Michigan.

MDPH worked collaboratively with the Michigan Hospice Organization and the Michigan State Medical Societ reviewing National Hospice Or ganization guidelines, hospice literature and rules from other states for the purpose of drafting hospice rules that would best meet the needs of the terminally ill in Michigan. Providers of hospice care also were asked to participate in the rule promulgation process.

Because hospice programs around the state vary in size, scope, structure and location, it took time to reach conensus. Small rural hospices ere concerned that the proosed rules did not consider ieir unique problems. To adress them Section 21411 of art 214 was amended by Act 6, PA 1984 which allowed xemption from licensure if the ospice met the following reuirements:

- Provided services to not iore than seven patients per ionth on a yearly average;
- Did not charge or receive ny fees for goods or services rovided;
- Did not receive third party eimbursement for goods or ervices provided.

Finally, on October 15, 1984 ie hospice rules were signed nd the hospice licensure proram became effective Ocober 30, 1984. Nationally, as f this writing, approximately 0 states have implemented ospice licensure.

Eighty Michigan hospice prorams have been identified as of June, 1986. Of these, 47 are exempt from licensure, 25 are licensed and eight programs are pending licensure. Of the 25 licensed programs, 15 are Hospice Medicare Certified and are primarily home health agency-based.

MDPH findings

During on-site licensure visits, several common elements among hospices were identified. They are as follows:

Pain and symptom management: All programs emphasize pain control and symptom management in accord with the philosophy that these two areas must be addressed first if all other caring measures are to be effective. The difficulty remains, however, that many attending physicians do not utilize current hospice pain and bowel protocols for their patients. Hospice staff continually strive to guide and educate attending physicians in appropriate pain management with the assistance of their hospice medical director.

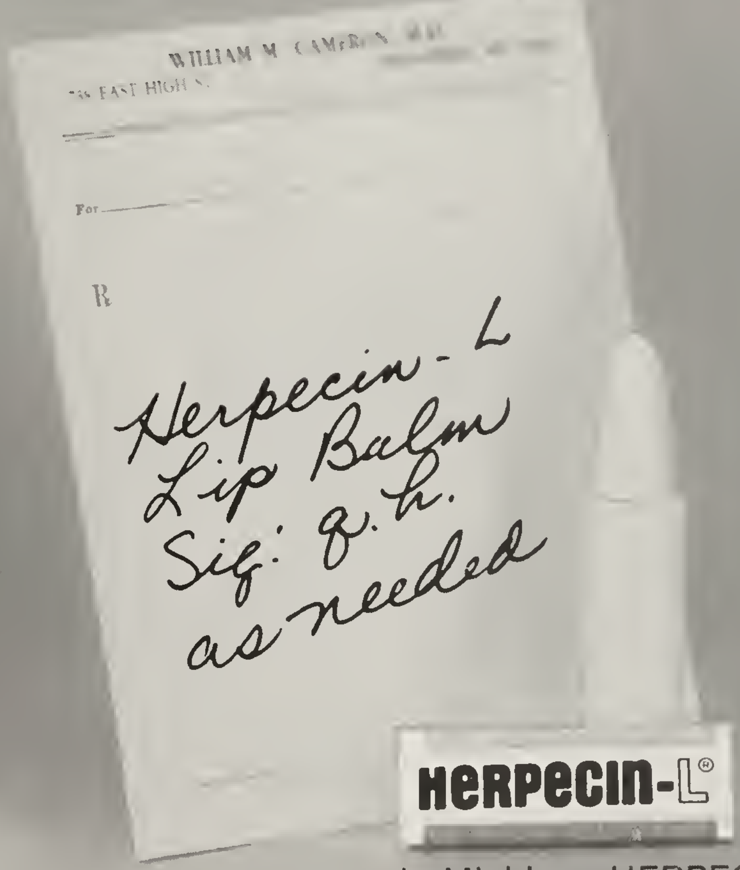
Medical supervision: All licensed hospice programs receive supervision from a medical director who serves either full-time or part-time. Many medical directors serve in a volunteer capacity. All programs encourage participation from the attending physician with a formal agreement that specifies his/her continued care and participation in the hospice program.

Family as the unit of care: All programs view the patient and his/her family as the unit of care.

Primary careperson: In a majority of the programs, the primary careperson is a family member, however, many programs identify and utilize other careperson options such as a

Continued on next page

Dx: recurrent herpes labialis



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friend or volunteer who accept the primary careperson role.

Interdisciplinary team: All licensed programs utilize an interdisciplinary team which usually meets weekly. The core hospice team consists of medical director, nurse, social worker, volunteer and spiritual counselor (often a volunteer). The attending physicians do not regularly attend the interdisciplinary team meeting.

Admission/discharge procedures: All programs define admission and discharge criteria. Often, as a potential admission or discharge occurs, the interdisciplinary team reaches consensus before taking action. All licensed programs require a signed informed consent form from the patient/family approving the provision of hospice care.

Counseling: All programs provide some type of counseling for the patient/family. These counseling services are often provided by professional volunteers with specialized skills.

Continuous care: All licensed programs provide 24-hour availability, seven days per week. Nurses (paid and volunteer) rotate on-call responsibilities. In a few instances the hospice administrator (a nurse) accepts the additional responsibility of on-call.

Respite care: Most programs are able to provide respite care ranging from a few hours to days. Respite care most frequently occurs in the patient's home.

Volunteers: All licensed hospices have well-written guidelines for volunteer orientation and training. All programs stress the importance of volunteer documentation in the patient/family record. Many programs also provide regularly scheduled support group meetings for volunteers. Volunteer job descriptions are utilized in all programs.

Bereavement services: All licensed programs provide bereavement follow-up for at least 13 months. The majority of the bereavement contacts are accomplished through the use of volunteers who have received documented bereavement training. Many programs also provide a yearly family memorial service. Additionally, many hospices organize group support programs for the community relative to bereavement issues.

Inpatient services: All licensed hospice programs have a policy provision to address inpatient care if needed. Often there are contracts with area hospitals to designate bed space for acute symptom control or respite.

Spiritual counseling: All hospice programs address the spiritual component of hospice care in varying degrees. A spiritual counselor (often a volunteer) attends interdisciplinary team meetings. In addition, many programs emphasize increased participation by local clergy. Spiritual assessment and documentation of the spiritual aspect of care seems to be the most inconsistent of all components of care.

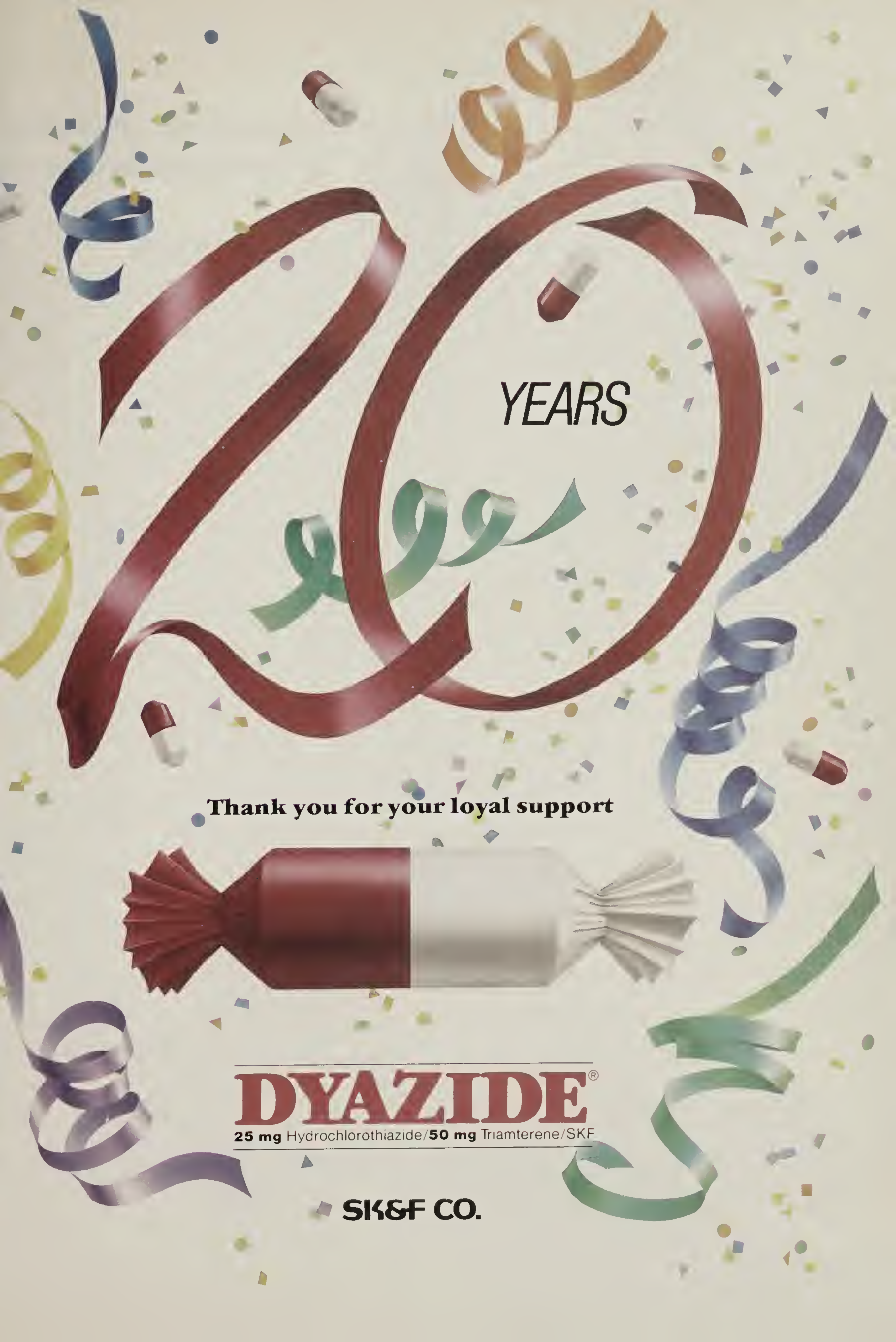
Future considerations

Michigan remains progressive with regard to hospice care. This is due to aggressive, proactive leadership of the state hospice organization and to individual programs dedicated to ensuring availability of quality hospice care in their communities. Future considerations for hospice care in Michigan include:

- **Multi-site hospice programs** which have a central administrative governing body responsible for satellite hospice programs are evolving. Mergers of small hospice programs with larger hospice entities already are becoming reality in Michigan.
- **Diversity of diagnosis** is becoming apparent for patients requesting hospice care. Terminality remains a requirement for hospice care yet "chronicity" is becoming evident in diagnoses other than cancer. For example, the NHO issued a policy statement in November, 1985 that encourages all hospice programs to provide care for AIDS patients.
- **Pediatric hospice care** is becoming a specialized area of care, and although many programs in Michigan identify low numbers of pediatric referrals, there is a need for continuing education in this area. The growth of pediatric hospices in densely populated areas should be encouraged.
- **Adult hospice day care** is on the horizon with a potential to better meet the needs of patients and primary caregivers who want to utilize the hospice program, yet cannot provide total in-home care during the day.
- **Hospice in long-term care facilities** is a consideration for patients who do not have an identified primary caregiver or future appropriate home situation. Utilization of long-term care facilities which understand and are committed to the hospice concept of care can be viable options for these patients.

Summary

Two primary concerns regarding hospice licensure in Michigan are quality assurance and consumer protection for the terminally ill. An important question being asked in Michigan is "How can programs preserve the hospice philosophy in light of continued regulation?" The answer, to some extent, lies in the licensure process itself. As the Michigan hospice rules assure quality hospice care in its most basic form through minimum standards, it also protects the name of hospice in its most pristine form. Hospice caregivers favorably view licensure as a means to verify the type of care they purport to provide, and also as a means to improve the quality of care they deliver.☐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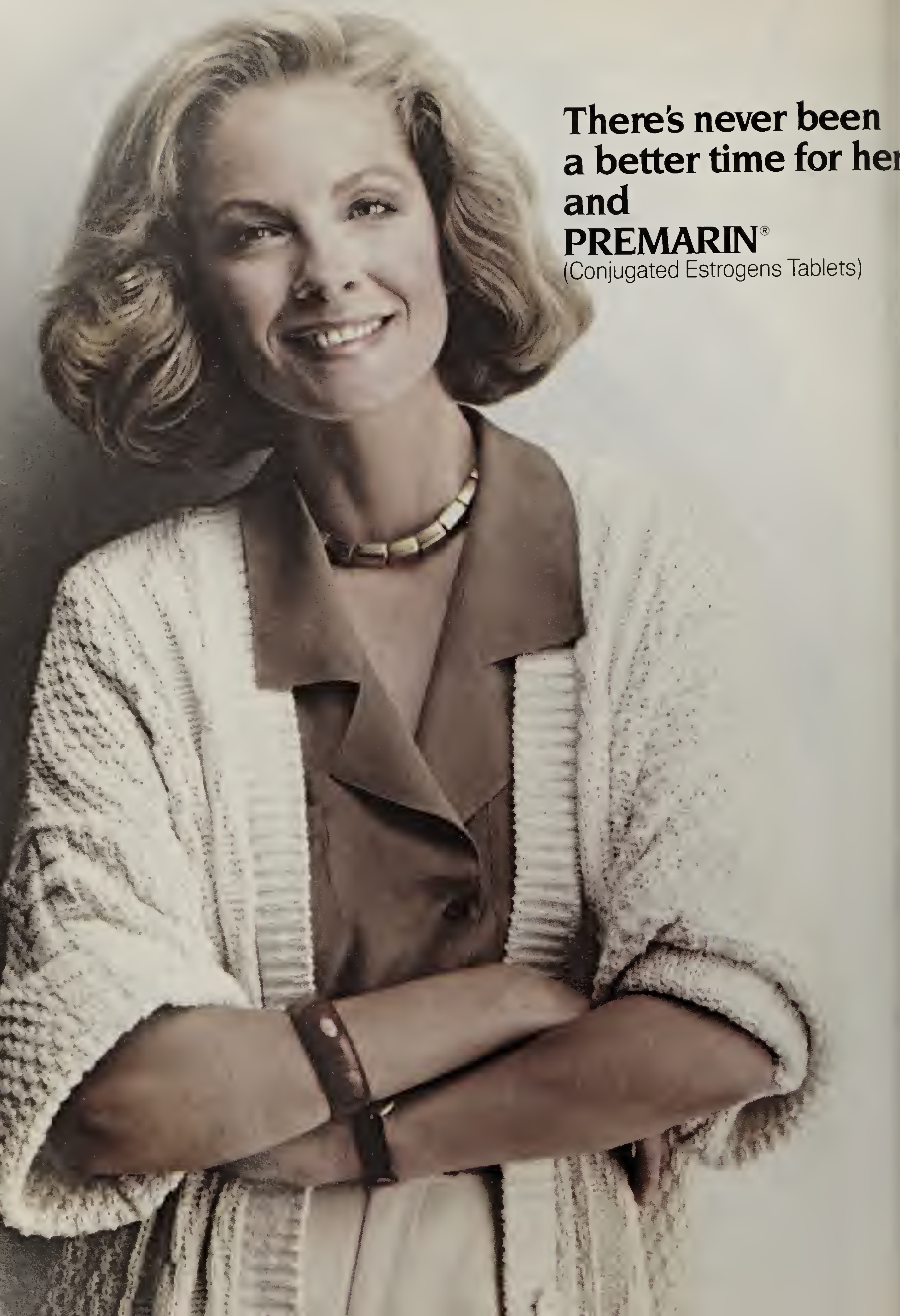
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Endometrial hyperplasia was significantly reduced when progestin was added to PREMARIN therapy for more than ten days a month.[1-4] The risk of endometrial hyperplasia may also be reduced through cyclic administration of unopposed, low-dose PREMARIN.

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PREMARIN used alone does not adversely affect lipid levels. In fact, a clinical study has shown a significant increase in HDL cholesterol—from 49.7 mg/dL to 56.4 mg/dL—and decrease in LDL cholesterol—from 165.1 mg/dL to 138.1 mg/dL—after one year of therapy with PREMARIN, 0.625 mg.[5]

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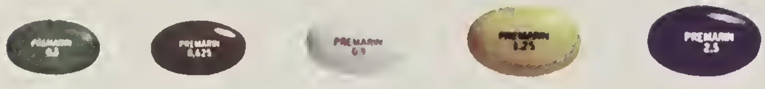

0.3 mg 0.625 mg 0.9 mg 1.25 mg 2.5 mg

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For atrophic vaginitis

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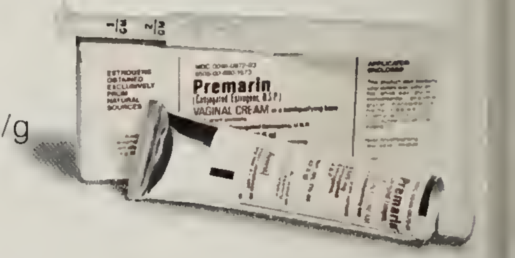
0.625mg/g



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream in a nonliquefying base

1 ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA.

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4 5 to 13.9 times greater than in nonusers The risk appears to depend on both duration of treatment and on estrogen dose In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses
2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.
The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare This risk has been estimated as not greater than 4 per 1,000 exposures Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects One case control study estimated a 4 7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000 In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters Tablets are available in 0 3 mg, 0 625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens Cream is available as 0 625 mg conjugated estrogens per gram
INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP) Moderate-to-severe *vasomotor* symptoms associated with the menopause (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) **Osteoporosis (abnormally low bone mass).** Atrophic vaginitis Kraurosis vulvae Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).
Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes Whether this will provide protection from endometrial carcinoma has not been clearly established There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects
CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions 1 Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease 2 Known or suspected estrogen-dependent neoplasia 3 Known or suspected pregnancy (See Boxed Warning) 4 Undiagnosed abnormal genital bleeding 5 Active thrombophlebitis or thromboembolic disorders 6 A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).
WARNINGS: Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement, it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use They should be used with caution in patients with cerebral vascular or coronary artery disease Large doses (5 mg conjugated estro
per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase
risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this size
used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tendern
abdominal mass, or hypovolemic shock Hepatocellular carcinoma has been reported in women taking estro
containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause
blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observe
patients on estrogen-containing oral contraceptives For this reason, diabetic patients should be care
observed Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastase
PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to
initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic org
and should include a Papanicolaou smear As a general rule, estrogen should not be prescribed for longer t
one year without another physical examination being performed Conditions influenced by fluid retention suc
asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation Certain patients
develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleed
mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the
of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increa
incidence of mental depression Patients with a history of depression should be carefully observed Preexis
uterine leiomyomata may increase in size during estrogen use The pathologist should be advised of estro
therapy when relevant specimens are submitted If jaundice develops in any patient receiving estrogen,
medication should be discontinued while the cause is investigated Estrogens should be used with care in patie
with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, o
young patients in whom bone growth is not complete If concomitant progestin therapy is used, potential r
may include adverse effects on carbohydrate and lipid metabolism

The following changes may be expected with larger doses of estrogen:

a Increased sulfobromophthalein retention.

b Increased prothrombin and factors VII, VIII, IX, and X, decreased antithrombin 3; increased
epinephrine-induced platelet aggregability

c Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone,
measured by PBI, T4 by column, or T4 by radioimmunoassay Free T3 resin uptake is decreased, reflecting
elevated TBG, free T4 concentration is unaltered

d Impaired glucose tolerance

e Decreased pregnanediol excretion

f Reduced response to metyrapone test.

g Reduced serum folate concentration.

h Increased serum triglyceride and phospholipid concentration. As a general principle, the administratio
any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in hu
milk

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contracepti
breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndro
amenorrhea during and after treatment; increase in size of uterine fibromyomata, vaginal candidiasis, chang
cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secret
(of breasts); nausea, vomiting, abdominal cramps, bloating, cholestatic jaundice, chloasma or melasma wh
may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss
scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migrai
dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggra
tion of porphyria, edema, changes in libido

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females

DOSAGE AND ADMINISTRATION:

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1. *Given cyclically for short-term use only.* For treatment of moderate to severe *vasomotor* symptoms, atrop
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will control symptoms should be chosen and medication should be discontinued as promptly as possib
Administration should be cyclic (eg. three weeks on and one week off). Attempts to discontinue or ta
medication should be made at three- to six-month intervals

2 *Given cyclically* Female castration. Osteoporosis Female castration—1.25 mg daily, cyclically Adj
upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level t
will provide effective control Osteoporosis —0 625 mg daily Administration should be cyclic (eg. three wee
on and one week off)

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measu
taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only For treatment of atrophic vaginitis or kraurosis vulvae

The lowest dose that will control symptoms should be chosen and medication should be discontinued
promptly as possible

Administration should be cyclic (eg. three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three-to-six month intervals

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer a
appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurri
abnormal vaginal bleeding

References:

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By Richard Murdock

Schools are giving wellness a chance

Two hundred eighty-five participants representing 4 Michigan school districts earned about wellness in the orkplace during the first Island Conference for School Workplace Wellness. The June onference was sponsored by he Michigan State Medical Soiety and 14 other health and ducation related organizaons and was held on Mackinac Island.

Why wellness in the school workplace?

Because medical research nd literature has demontrated the relationship beween lifestyle decisions and ealth status, it is no longer ecessary to justify the conept of health promotion and wellness. Rather, it is necessary to carefully organize and maintain programs that demonstrate effectiveness in the health promotion area. It is generally recommended that the optimum setting for adult health promotion programs is the workplace, and as such programs utilize information and techniques common to the education field, the school setting is perhaps the most appropriate area to organize wellness programs.

The Special Report on the Michigan Model for Comprehensive School Health Education featured in the April, 1986 issue of *Michigan Medicine*, explained the development and growth of a wellness curriculum for Michigan's

Continued on next page

Richard Murdock is a health planning consultant with the Office of Health and Medical Affairs, Michigan Department of Management and Budget and acted as Island Conference coordinator.

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WELLNESS/Continued

school children. This growth will be hastened in school districts that already recognize the value of health promotion for their employees. The positive role-models which employee wellness programs in schools can produce may prove to be invaluable components in the success of school health education.

Purpose of the Island Conference

Employee health promotion programs are beginning to take place in many areas of Michigan. These programs run the continuum from one-time distribution of pamphlets to comprehensive ongoing programs. Research has indicated that successful results in health promotion are more likely to occur in programs that are based upon assessment of need, joint involvement in program planning and development by employees and employer, and identifiable evaluation. The Island Conference was designed to acquaint participants with various intervention activities that could be part of a wellness program, guidelines for the development of wellness programs, experiences of districts which have already begun such programs, and identification of potential resources that may be available to help in the development or operation of programs.

A key distinction of the Island Conference from that of similar conferences was the requirement of "team" registration. The teams had to represent various school employee categories (i.e., instructional, administrative and service). Furthermore, each team was required to develop an "action plan" during the conference that would identify how it would initiate or enhance wellness programming in its local area.

Results and future activities

The Island Conference offered 31 different workshops, most of which were presented twice, four keynote presentations, a specially-prepared week-long menu that was consistent with the wellness theme, and organized fitness activities. The island setting made for a stress-reducing environment without interruptions that are often present at other locations.

The "action plans" developed by the participating teams are presently being reviewed but reveal serious and well-thought-out strategies for bringing health promotion programs to a higher standing. These plans will be shared with other teams that attended the Island Conference, representatives of the sponsoring and cooperating organizations, and others upon request. Furthermore, follow-up surveys will be undertaken to measure success in the implementation of the strategies outlined in the plans.

The Island Conference Steering Committee, chaired by James Tarrant of the Michigan Health Council, will evaluate the Island Conference and will plan for a 1987 conference. (Tentative plans are to hold the second Island Conference June 14-19, 1987 again at the Mackinac Hotel and Conference Center.)

The involvement of the Michigan State Medical Society in support of the Island Conference brought credibility and expertise that helped to assure success. Similarily, local physician involvement with school employee wellness programs will assist in their success.☐

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Rosenzweig

Talbott

John Judson, MD, Benton Harbor cardiovascular surgeon, and **Melvin Anderson, MD**, were appointed to the board of trustees of the American Heart Association of Michigan for three-year terms.... **Norman Rosenzweig, MD**, was presented with the Michigan Psychiatric Society's Area IV Warren Williams Award, during the MPS summer meeting in Traverse City. Doctor Rosenzweig announced that he will contribute the $1,000 award to help further the participation of residents in Area IV Council activities. The MPS simultaneously presented its Distinguished Service Award to Doctor Rosenzweig "in recognition and appreciation for his unstinting service to psychiatry." ...**Anna H. Broecker, MD**, and **Dale L. Kessler, MD**, were re-elected to the Board of Directors of Michigan Physicians Mutual Liability Co. (MPMLC) to serve three-year terms....**Joseph R. Lentini, MD**, was named director of the Grand Rapids Convention Bureau....**Morris Moore, MD**, and **Lawrence M. Probes, MD**, lent their support to Operation Caravan, organized by the Institute for Global Education, in collecting medical supplies for Nicaragua. ...**Robert E. Ribbe, MD**, and **Fred S. Stockinger, MD**, recently lectured in Kenya at the Seventh Symposium on Continuing Medical Education for missionary physicians, surgeons and dentists. It was attended by 170 missionary doctors from 37 countries....**Larry J. Robson, MD**, has been named president of the Michigan Chapter of the American College of Surgeons....**Timothy M. Talbott, MD**, and an associate received the Northwest Society of Colon and Rectal Surgeons Award for their work in post-operative pain control. ... **Frederick W. Bryant, MD**, president of the Michigan Ophthalmological Society has announced that the national toll-free Helpline that provides medical eye care for older Americans—1-800-222-EYES—has recieved more than 100,000 calls since it opened in January....The Michigan Occupational Medical Association has named its officers and board of directors for 1986-87. **Howard J. Sawyer, MD**, Southfield, was named president. **David Jacknow, MD**, will serve as president-elect. Other officers elected were **Donald J. Sherman, MD**, West Bloomfield, vice-president, and **Richard A. Rood, MD**, Warren, secretary-treasurer....**Elliot N. Fralberg, MD**, Bloomfield Hills, recently was elected president of the Michigan Society for Gastroenterology....**David B. Hawtof, MD**, Southfield, has been named president-elect of the Southeastern Michigan Surgical Society....**Judith E. Tintinalli, MD**, recently was elected to the board of directors of the American Board of Emergency Medicine. She was named secretary-treasurer. ...**Sheldon N. Siegel, MD**, recently was appointed to the American Psychiatric Association's Committee on Quality Assurance, which deals with peer review, utilization review/case management and liaison qualifications....**Raymond A. Gagliardi, MD**, and **Robert D. Steele, Jr., MD**, have been appointed Examiners by the American Board of Radiolo ...**John C. McCabe, MD,** Ann Arbor, has the internationa Federation of Voluntary Health Service Funds. Doctor McCabe currently is chairman of the board and chief executive officer of Blue Cross and Blue Shield of Michigan. ...**John Mucasey, MD,** Detroit, has been appointed to a two-year term on the board of directors of the American Academy of Medical Directors. Doctor Mucasey currently is president of the Woodland Medical Group in Novi. ...**William N. Kelley, MD,** Ann Arbor, has begun a one-year term as president of the American Rheumatism Association. Doctor Kelley is the John G. Searle Professor of Internal Medicine and chairman of the Department of Internal Medicine at The University of Michigan Medical School and is recognized for his research into rare inherited diseases. ...**Richard Mudd, MD,** Saginaw, has been honored as the 16th recipient of a Saginaw YMCA Life Membership. At 85, Doctor Mudd plays handball three times a week and for 50 years has been encouraging other Saginaw YMCA members to play handball. Doctor Mudd has played handball at 25 different YMCAs across the country. ...**Sanford N. Cohen, MD**, Detroit, was named provost at Wayne State University. Doctor Cohen is Associate Dean of the School of Medicine and coordinator for Student Affairs Programs in Medicine at WSU. ...**Harry Maisel, MD,** Detroit, professor of anatomy at Wayne State University, will receive the Board of Governors Faculty Recognition Award for his contributions in vision research and for his book, *The Ocular Lens: Structure, Function, and Pathology.*☐

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By Shirley A. Prus

Auxilians: buffers in difficult times

Prust

As I sit here and look at the beautiful fall color it is hard for me to turn from such serenity to the turmoil of present day medicine and its effects on our lives.

We have heard so much about the problems for so long, we may resign ourselves to what some say is inevitable: there will be no meaningful changes in the medical liability area, or fee for service practice is dead.

Well, I disagree, and will continue to point out to Auxilians what we can do to buffer the changes.

Recently I attended one of the MSMS Task Force on Professional Liability forums. The information provided was a good review of the work that brought the bills to passage; the give and take process in the political arena.

Conversation with physicians after the conference was depressing. Gynecologists quoted malpractice premiums ranging from $60,000—$80,000 yearly for $100,000/$300,000 coverage. Many are "going bare," have become hospital employees, or are leaving the state.

Physicians discussed the pros and cons of bankruptcy! And I asked myself, what has happened to the noblest profession in the world and what can we Auxilians do about it?

Education is the key. We must become familiar with the various components of medicine's "alphabet soup:" HMO, PPO, IPA, DRG, etc. We must study how they affect the public, medical care, and our spouses' ability to deliver. Our duty is to become knowledgeable, then spread the word.

If you doubt the need, just spend a little time in your spouse's office. The extra paper work, the telephone calls all consume time, and it sometimes seems the main purpose is to control cost, not medical care.

Political awareness

I really wonder if our political representatives know what is going on. This is where an Auxilian's job begins: write them, inform them, and keep doing it.

Physicians, I urge you to encourage your spouses to join Auxiliary. With increased membership we can become more effective advocates for you. ☐

Mrs. Prust, Frankin, is MSMS/A president

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By Evelyn Dykewic

MSMS/A urges vaccination of nurses

The following letter was sent to directors of Michigan nursing programs:

The Michigan State Medical Society Auxiliary recently passed a resolution requesting that the Michigan schools of nursing implement an appropriate immunization policy for their respective students.

A May, 1985 Michigan Department of Public Health survey of Michigan colleges and universities revealed that only 33 percent of public four year colleges and universities and 66 percent of public junior and community colleges had a measles and rubella immunization requirement. Nursing students were included in this group. Since measles and rubella predominantly occur in the over 15 under 30 year age group and the disease is more severe in young adults, immunization against these and other infectious diseases should be required.

The 1985 edition of the *Guide for Adult Immunization* by the American College of Physicians recommends the following immunizations for health care personnel: tetanus-diptheria, measles, rubella, mumps, poliomyelitis, influenza and hepatitus. The Guide states that "special attention should be given to immunizing health care personnel, either because of the documented increased risk of exposure to certain preventable infectious diseases or to minimize the likelihood of transmission of certain infectious disease, such as influenza and rubella, within the hospital, clinic or physician's office."

The MSMS Auxiliary strongly urges that your students be properly immunized and thus protected against these diseases. ☐

Mrs. Dykewicz, Flint, is a member, MSMS/A Committee on Health Projects and MSMS Liaison Committee with the Michigan Department of Public Health.

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eported cases of Reye's Syn-
rome since October 1, 1985.
ecent surveillance of in-
uenza activity in the Southern
emisphere indicates that the
$_1N_1$ virus has undergone anti-
enic drift from the H_1N_1 com-
onent at the currently availa-
le trivalent influenza vaccine.
ecause of this, a supplemen-
ary monovalent vaccine, with
he new H_1N_1 variant, is in
reparation. Persons under age
5 are unlikely to have been
xposed to H_1N_1, and are felt
o be at risk to this new vari-
nt. The May 23, 1986 (Vol.
5/No. 20) and the August 15,
986 (Vol. 35/No. 32) "Mor-
idity and Mortality Weekly
eport" discuss recommenda-
ions for influenza vaccination
or the 1986-1987 season. The
CIP specifically recommends
accination of children on
ong-term Aspirin therapy.

ARC and the "worried well"

As more people seek testing for the virus causing AIDS, public and private organizations nationwide are strengthening steps to counsel them, as well as AIDS victims, those who have ARC (Aids Related Complex) and the "worried well," people who have AIDS antibodies but show no apparent signs of being ill.

Many of these people need help coping with stress created by the constant underlying fear of the disease and drastic changes in lifestyles, according to Doctor Philip Muskin, Deputy Director, Department of Consultation-Psychiatry, Columbia Presbyterian Medical Center, New York.

Thousands of professionals trained in AIDS counseling and education conduct pre- and post-test sessions with everyone who takes the test at any of the approximately 650 publicly-supported testing centers. These Alternative Testing Sites (ATS) are found nationwide and usually are affiliated with local public health departments.

Maternal death reporting

Michigan has one of the earliest continuing studies of statewide maternal mortality cosponsored by the Michigan Department of Public Health and the Michigan State Medical Society's Committee on Maternal and Perinatal Health. The purpose and function of this study is educational, pointing to areas of deficiency in the public's knowledge, and to common or repetitious problems for the medical profession. Recent analysis by the Centers for Disease Control (CDC) reflects a 25-30 percent underreporting of maternal deaths through state vital statistics systems.

Michigan *has* a regulation covering the reporting of maternal deaths by anyone knowing of the deaths, including medical record professionals, hospital administrators, medical examiners, physicians, nurses and others interested in the study. The basic information desired is the name, address, and date and place of death of the deceased. Although reporting forms are available and supplied by the State Health Department, a note sent to the following address will increase the completeness and accuracy of Michigan's records: Lee B. Stevenson, MD, Center for Health Promotion, Michigan Department of Public Health, PO Box 30035, Lansing, MI 48909.☐

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

Date: November 18, Current Topics in Pediatric Infectious Diseases. Location: Childrens Hospital of Michigan. **Sponsor:** Children's Hospital of Michigan. **Contact:** Educational Services Department, Children's Hospital of Michigan, (313)745-5455. **Approved for:** 4 hours of Category I Credit.

Date: November 19-21, Laser Medicine and Surgery: Specialty Applications. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Anne Karolak, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 22.5 hours of Category I Credit.

Date: November 19, Laser Medicine and Surgery: Symposium and "Hands-On" Workshop for General Surgeons, Thoracic Surgeons, and Gastroenterologists. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Betty Phillips, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 7.75 hours of Category I Credit.

Date: November 20, Laser Medicine and Surgery: Symposium and "Hands-On" Workshop for Urologists. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Betty Phillips, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 8.3 hours of Category I Credit.

Date: November 21, Laser Medicine and Surgery: Symposium and "Hands-On" Workshop for Gynecologists. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Betty Phillips, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. **Approved for:** 7.5 hours of Category I Credit.

Date: November 22, Advances in Radiology. Location: South Macomb Hospital Auditorium. **Sponsor:** South Macomb Hospital. **Contact:** South Macomb Hospital, Department of Medical Affairs (313) 499-4915. **Approved for** 6 hours of Category I Credit.

Date: December 6, How to Manage Tachycardias and Bradycardias. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Kim Sadlocha, Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3073. **Approved for: 6 hours of Category I Credit.**

Date: December 6, Clinical Interrelationships—The Brain and The Heart: Psychological Factors in Heart Disease and Anxiety. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Gayle Fox, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 7 hours of Category I Credit.

Date: December 15-19, Principles of Manual Medicine. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine, College of Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: January 17, 1987 '87 Superbowl of Osteopathic Medicine. Location: Michigan Osteopathic Medical Center, Detroit. **Sponsor:** Michigan Osteopathic Medical Center. **Contact:** Sheila Smith, Coordinator, CME & Special Programs, Michigan Osteopathic Medical Center, 2700 Martin Luther King Jr., Blvd., Detroit 48208 (313)361-8020. **Approved for:** 7 hours of Category Credit.

Date: February 1-6, 1987 Eleventh Annual Midwinter Family Practice Conference. Location: Boyne Highlands Inn, Harbor Springs. **Sponsor:** University of Michigan Medical School. **Contact:** Gayle Fox, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor 49109-0201 (313)763-1400. **Approved for:** 21.5 hours of Category I Credit.

Date: March 18, 1987 Dermatology. L cation: Saint John Hospital, Detroit. **Spo sor:** Saint John Hospital Continuing Me ical Education Committee. **Contact:** Car Mastroianni, Program Coordinator, CM Saint John Hospital, 22101 Moross Roa Detroit 48236 (313)343-3877. **Approve for:** 8 hours of Category I Credit.

Date: March 25-26, 1987 Michigan Co ference on Maternal and Perinatal Healt Location: Hyatt Regency, Dearborn. **Spo sor:** MSMS. **Contact:** Sherry Fent, 120 W Saginaw, East Lansing 48823 (517)337 1351. **Approved for:** 13 hours of Cate gory I Credit.

Date: April 3-5, 1987 Tutorial on Level Myofascial Release Technique. Location Kellogg Center for Continuing Education MSU. **Sponsor:** MSU College of Osteo pathic Medicine and College of Huma Medicine. **Contact:** Sandy Kilbourn, MA Director of Continuing Medical Education MSU College of Osteopathic Medicine A306 E. Fee Hall, East Lansing 4882 (517)353-9714. **Approved for:** 24 hour of Category I Credit.

Date: May 15-17, 1987 The Differentia Diagnosis of Musculoskeletal Pain: Emphasis on the Low Back. Location: Kellogg Center for Continuing Education MSU. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandy Kilbourn Director of Continuing Medical Education MSU College of Osteopathic Medicine, A306 E. Fee Hall, East Lansing, MI 48824 (517)353-9714. **Approved for:** 20 hours of Category I Credit.

Date: May 20, 1987 Current Update in the Treatment of Breast Carcinoma. Location: Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital Continuing Medical Education Committee. **Contact:** Carol Mastroianni, Program Coordinator, CME, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313)343-3877. **Approved for:** 8 hours of Category I Credit.

Date: May 27-31, 1987 Tutorial on Level II Manual Medicine Techniques (Below Diaphragm). Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU College of Osteopathic Medicine, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

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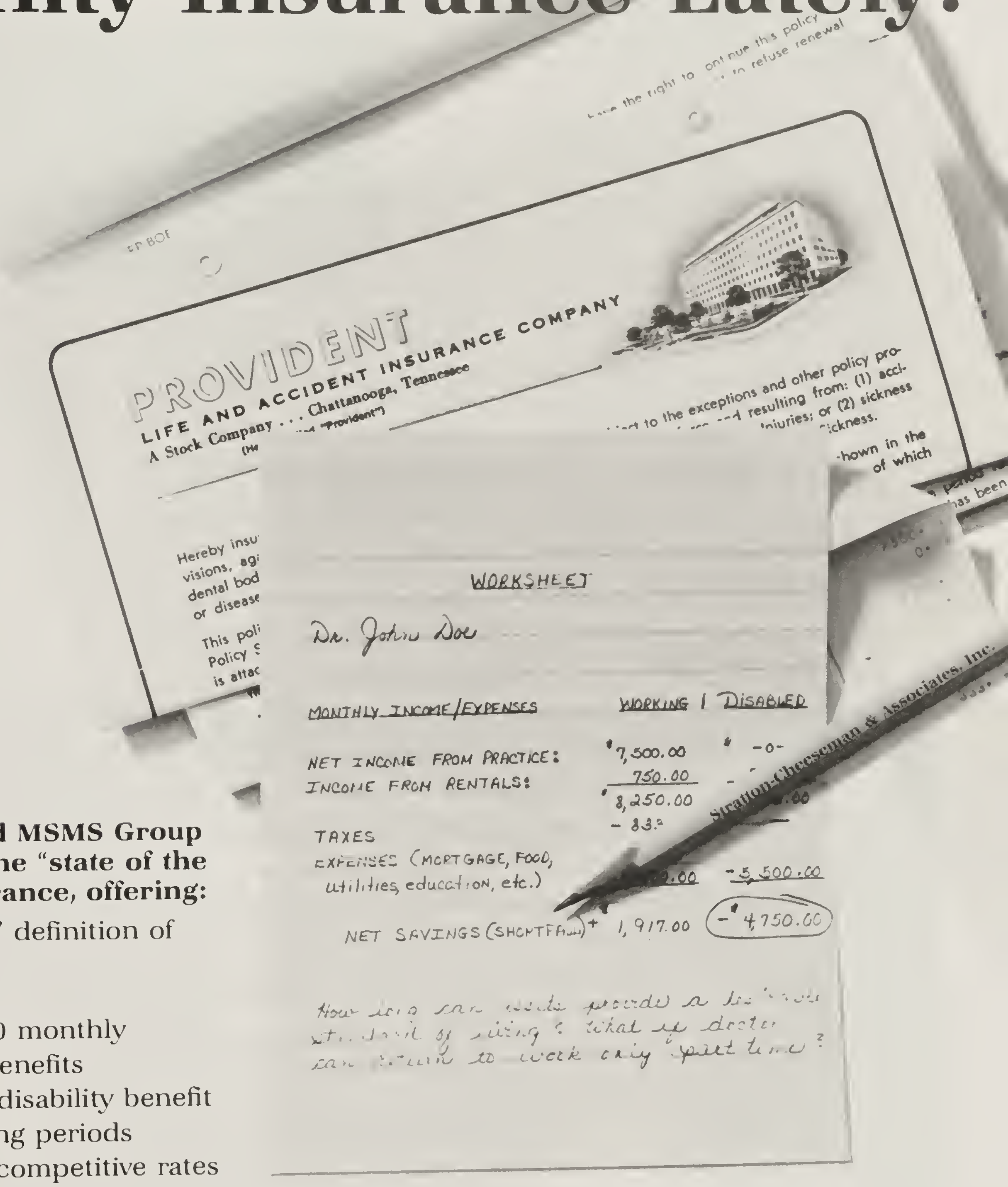
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Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Nancy Ann Ajemian, MD—FP
18101 Oakwood Blvd. Box 2500
Dearborn 48123

Nitin R. Ambani, MD—U
505 Keefer Dr.
Albion 49224

Pastor A. Aperocho, Jr., MD—AN
South Haven Comm. Hosp.
South Haven 49090

Peter J. Aronson, MD—D
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Detroit 48202

David Benjamins, MD—N
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Steven W. Bloink, MD—FP
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Flushing 48433

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Muskegon 49441

John E. Brunner, MD—END/IM
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Grosse Pte. 48230

Elie J. Chidiac, MD—AN
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Northville 48167

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East Detroit 48013

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Coldwater 49036

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U of M Hospital Dept./Anesth.
Ann Arbor 48109

Thomas R. Shaw, MD—NPM/PD
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Janette D. Sherman, MD—IM
25811 W. 12 Mile Rd.
Southfield 48034

SMS, MSMS/A, MA & MEDICAL SSISTANTS

ovember 19 — MSMS Board f Directors Meeting, MSMS eadquarters, East Lansing, ontact: William Madigan 517)337-1351.

ovember 19-21 — AMA International Conference on Non-ilitary Radiation Emergencies, Pan American Health Organization Headquarters, Washington, DC, contact: AMA at 1-800-621-8335.

December 7-10 — AMA Interim Meeting, Las Vegas Hilton, Las Vegas, contact: Bruce Ambrose (517)337-1351.

January 21, 1987 — MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, contact: William Madigan (517)337-1351.

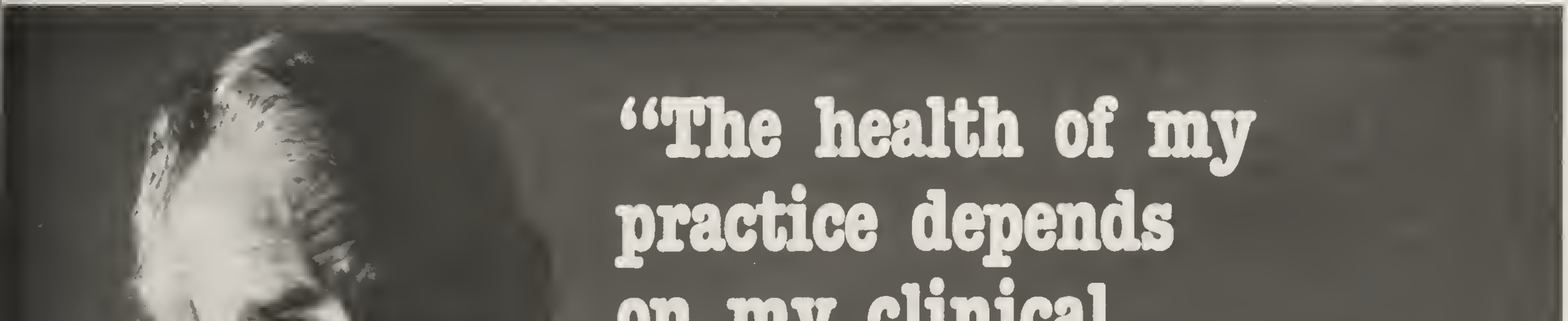
March 18, 1987 — MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, contact: William Madigan (517)337-1351.

April 24-25, 1987 — MSMS House of Delegates, Amway Grand Plaza, Grand Rapids, contact: William Madigan (517)337-1351.

July 16-19, 1987 — MSMS Board of Directors Midsummer Meeting, Deer Lake, Boyne Mountain, contact: William Madigan (517)337-1351.

September 23, 1987 — MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, contact: William Madigan (517)337-1351.

November 18, 1987 — MSMS Board of Directors Meeting, MSMS Headquarters, contact: William Madigan (517)337-1351.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FAMILY PRACTITIONER wishes to relocate in Midwest. Active - excellent references. Currently part time medical director for HMO in addition to practice. Clinical faculty with medical school. Please reply to Box 100, Michigan Medicine, 120 W. Saginaw, Box 950, East Lansing 48823.

By James H. Sammons, M

Old attitudes, new realities

This month MSMS President Thomas R. Berglund, MD, shares excerpts of a speech given by AMA Executive Vice-President James H. Sammons, MD, at the American Association of Medical Society Executives annual meeting in Seattle.

"It seems to me that if there is anything that is the archetypical new reality within the AMA, it is the reality that there is a *new* AMA. It is not the same AMA that it has been in the past, it is never going to *be* the same AMA as it was in the past. Its opportunities are infinite, its desire to fill those opportunities continues to grow. . . .

"From where I sit, I watch this absolute nonsensical competition between counties and states and between states and the AMA. It just absolutely staggers my imagination. We are a bunch of little children in the same household and we are fighting over the last cookie momma has left on the plate. Why don't we stop that nonsense and decide that we are gonna help momma make a whole new set of cookies, and put them on a different plate?

"Instead, I see counties fighting states and specialty societies fighting the AMA and states fighting the AMA. I hear specialty societies say we don't need the AMA. . . .

"People are out there ready to splinter us even further if we give them half a chance—and it seems to me like we are giving them more than half a chance. There are some out there as well-organized as we are, and maybe even a little better. And there are some out there who don't let truth stand in their way. If they can sell their story without being bothered by the truth, then it's open season on you and on us.

"There's a difference, you know, between apple-polishing and image-polishing and we've been through this exercise in the AMA. Let me tell you my definition: apple-polishing in medicine is going out to the public with a self-serving set of recommendations or programs because we want to look good. Imaging-polishing is when we go out to the public with a set of programs and statements that are dedicated and directed towards the improvement of the public health of this nation, and the continuation of the care of all 240 million of them. . . .

"It's my age group I'm worried about. These old fossils have decided that everybody doesn't love 'em like they used to, and I don't either, and they want us to correct their image. Well, we can't do that. There's not a doctor in this country that wouldn't profit as I have preached for years and get no disciples at all. . . .

"Well, I hear a lot of conversation around the country about doctors being demeaned and they're going to have thei role reduced—indentured employees or medical technicians I don't believe that. I don't believe that at all. I've been in this profession for 35 years and I am just as convinced today as I was the day I walked across that stage in 1951 with my degree that any doctor who really cares, any doctor who really tries, is going to find patients who really need help, and want help. Between the two of them they can weld the most magnificant joint venture in the history of man. And I don't care if we have DRGs, prospective pricing, PROs or anything else. There is absolutely nothing except physician apathy that keeps us today from being just as strong and just as powerful as we were in 1951. Because as long as the doctor *cares*, as long as the doctor is honest and competent, the patient will know it, and when that patient knows it, all of these other people will have to talk to themselves. . . .

"I think there are some new realities out there. I hope you go out there and think about it, and as you think of new realities, write me and tell me. I would like to hear from you as to what you think the new realities are. We don't need any help looking at old attitudes—goodness knows we've been looking at 'em for far to long. What we need is the guts to look at the *new* realities.☐

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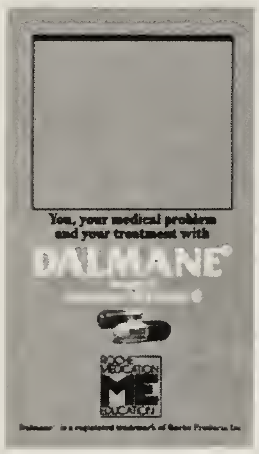
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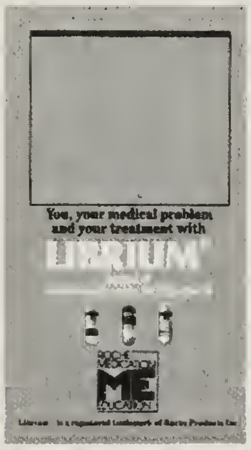
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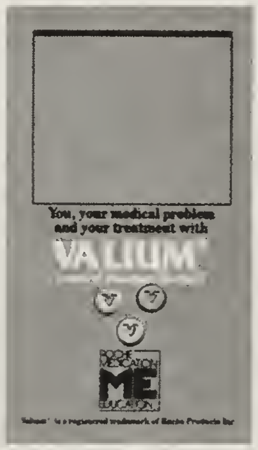
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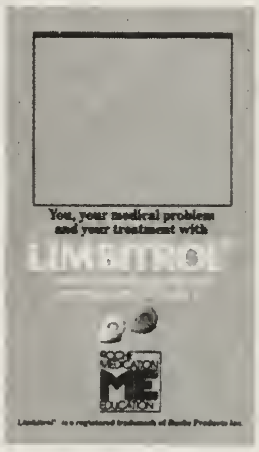
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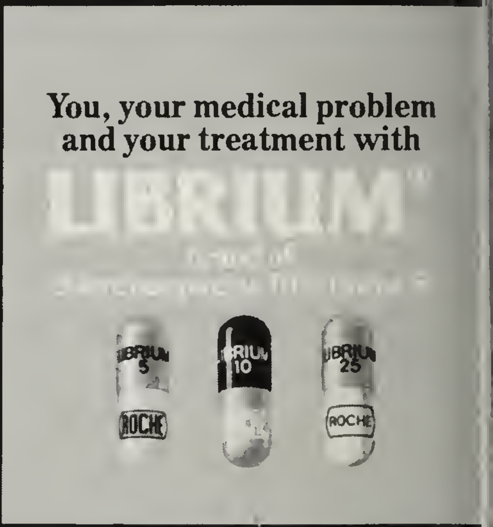
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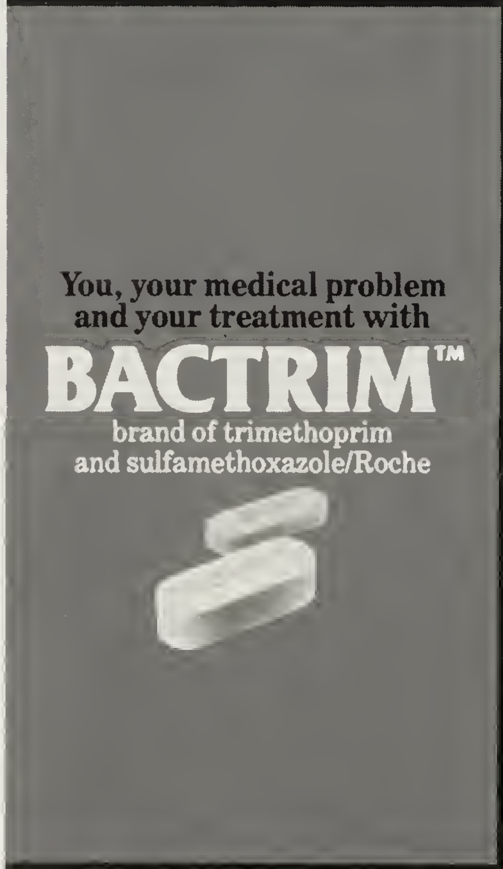
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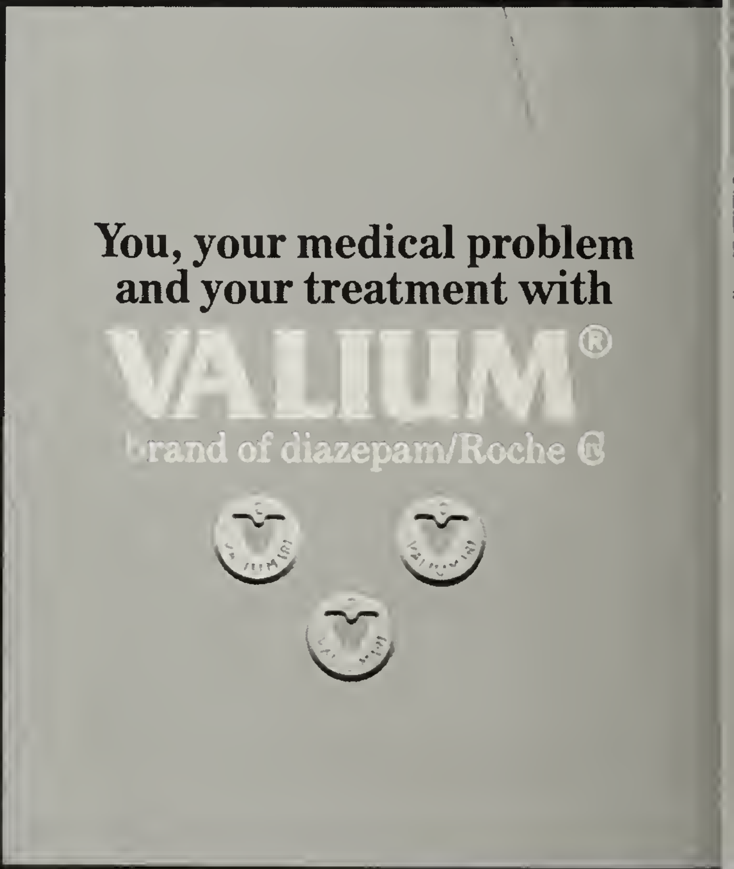
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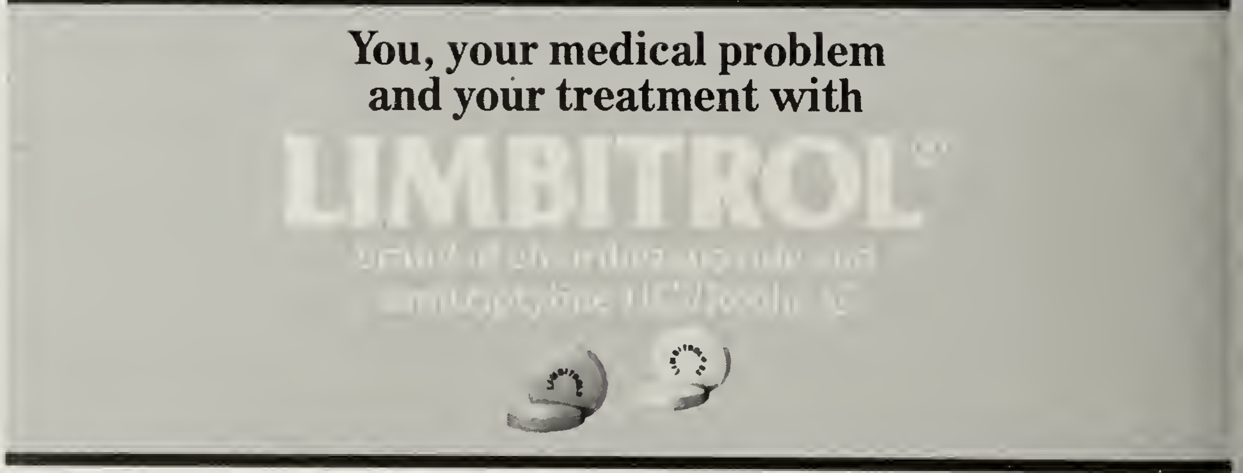
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MICHIGAN MEDICINE

December 1986 AWARD-WINNING JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 85, No. 12

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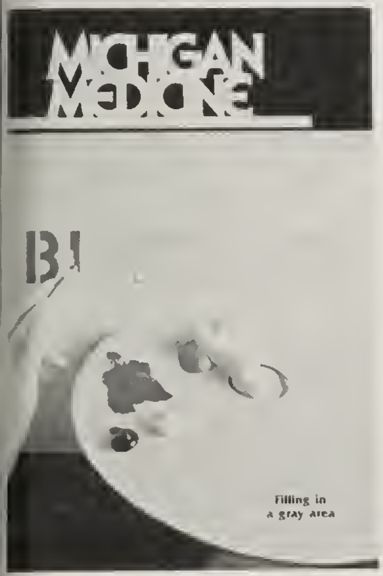

›ut the cover: Not black, white, but a gray area in ch there are few hard and rules — that is the nature ›ioethics, the subject of month's Special Report. **›to by Kim Kauffman.**

ıext month's issue of *:higan Medicine:* "Prepar- for the 90s: Controversies Care" is the theme of the h annual Michigan Confer- e on Maternal and Perina- Health. Our January issue l feature a complete pre- inary program of the March -26 conference at the Hyatt gency Dearborn.

Special Report

658 "Bioethics, the sum aggregate of human attitudes in relation to the conduct of health activities, is a concern for life." That first line of our Special Report was written by Fred W. Bryant, MD, chairman of the MSMS Committee on Bioethics. It is an appropriate beginning to a report presented as food for thought by the Bioethics Committee. Much of the material is from the recent MSMS Annual Scientific Meeting at which a trio of courses — Bioethics: From Here to Eternity, Parts 1, 2 and 3 — covered several controversial issues, including Baby Doe and terminal care decisions. Our report includes the wording of a broadened AMA opinion on life-prolonging treatment: Howard Brody, MD; Fred W. Bryant, MD, and William B. Weil, Jr., MD.

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By Richard J. McMurray, MD

Confidentiality and *Catch-22*

As I raked my lawn a few days ago, and necessarily bagged all the leaves, it jogged my memory of yesteryear: a time when it was simple to rake the leaves into a pile and, when appropriate, light a match. The smell of burning leaves, the smoke smell on your clothing—how memorable— occasionally mixed with the smell of roasting marshmallows—how delightful. Now it is illegal to burn leaves.

It seems the practice of medicine has evolved over this period of time in much the same way. Now all elements of patient care must fit into a certain scheme of regulations and constraints along with trying to protect oneself from the ever present threat of medical liability. Every day there are new roadblocks to the previously memorable, usually delightful, patient/physician relationship.

The FTC, as a matter of fact, forced the AMA to rewrite the Principles of Medical Ethics under the threat of anti-trust litigation, etc. I personally feel very comfortable with our present principles of medical ethics and I believe the present seven principles very adequately replace the previous 10 principles in a manner which clarifies and updates the language and eliminates much ambiguity. The new principles attempt to establish a proper and reasonable balance between professional standards and contemporary legal standards in our changing society.

I would like to discuss the fourth principle of medical ethics as it relates to present society.

Number IV states, "a physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law."

This, of course, is the principle which upholds the long-honored patient/physician privileged communications. Confidentiality of this nature made the national news a few weeks ago when the Pittsburgh press reported that at least 23 airline crew members, including a pilot near death from cocaine overdose, had been treated previously at Pittsburgh hospitals for medical crises related to drug abuse. Hospital officials said confidentiality laws prevented reporting such abuses. The Council on Ethical and Judicial Affairs writes opinions based on the seven principals of medical ethics. The opinion on confidentiality states:

The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this

Continued on next page

Doctor McMurray is MSMS' immediate past president; a member of the MSMS Board of Directors and Publications Committee.

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phasis on socio-economics, legislat
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18 66

illusioned MDs
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yers

ead with concern Doctor
nael Galvin's account in the
ober, 1986 issue of his in-
turmoil after he saved the
of a seven-year-old child
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malpractice liability at-
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in particular for his inabil-
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omplishment.

octor Galvin's sincerity is
ious. No responsible in-
dual can be unconcerned
ut the circumstances which
obviously so stressful to
and to all of the Doctor
vins in practice. It is pre-
ly because the situation is so emotionally charged that one ought to be absolutely certain about the accuracy of what is said about it.

Doctor Galvin concludes that the situation is the sole responsibility of lawyers. "A good lawyer might find a way to make me look bad to a jury of lay people, and that's who would judge me in the end." He fails to note the fact that the case could never reach the jury unless a fellow doctor testifies that in his or her professional judgment, the treatment accorded the patient did not meet standards of reasonable medical care. The reality is that my profession cannot recover a malpractice judgment against the Doctor Galvins of this world without support for the validity of the claim from a member of the medical profession. In fact, a lawyer who fails to pursue a client's medical malpractice claim which is supportable by competent medical testimony would himself be subject to malpractice liability.

I know that many in the medical profession will say that there are doctors willing, for a fee, to prostitute themselves and falsely certify malpractice on the part of a fellow doctor. The less than 1:4 ratio of jury verdicts for and against doctors, even in today's supposedly hostile climate, suggests that this problem is not nearly as pervasive as the medical profession likes to believe.

But even where it may in fact happen, I respectfully suggest that no objective observer could reasonably conclude that the resulting malpractice award can be blamed solely upon the legal profession.

Michael Franck,
Executive Director
State Bar of Michigan

NFIDENTIALITY/Continued

sclosure with the knowl-
dge that the physician will
spect the confidential na-
re of the communication.
ne physician should not re-
eal confidential communica-
ons or information without
e express consent of the
atient, unless required to
o so by law.

ow I quote to you the
higan Statute 600.2157:

> 600.2157 Physician-patient
> rivilege; waiver.
> Sec. 2157. No person duly
> uthorized to practice medi-
> ne or surgery shall be al-
> wed to disclose any infor-
> ation which he may have
> cquired in attending any pa-
> ent in his professional
> haracter, and which infor-
> ation was necessary to
> nable him to prescribe for
> uch patient as a physician,
> r do any act for him as a
> urgeon.

nd the Public Health Code
Michigan states:

> For physicians and other health professionals, "betrayal of a professional confidence" is "unprofessional conduct" and a violation which should be punished by "reprimand, probation or suspension" by the Board of Medicine or appropriate health profession's licensing board.

For hospitals, the Public Health Code states:

> Department officers and employees shall respect the confidentiality of patient clinical records and shall not divulge or disclose the contents of records in a manner which identifies an individual except on court order.

Surely we physicians are going to find ourselves in greater conflict with our own moral ethics, our own professional ethics and our own state statute and public health code, as we deal with our patients who may have real problems which may not only affect their health, but may affect the people of the community.

Yes, you can report the disease AIDS, because it is a communicable disease and thus reportable, but how about a positive antibody test for HTLV3 in a dentist, physician, lab technician or anyone else who might have dangerously close accidental contact with an unsuspecting public? Think about the school bus driver who you know has a drug or an alcohol problem — when does confidentiality end — with the state statute or with your moral and professional ethics?

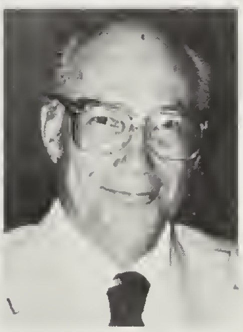
As I indicated earlier, life for the physician has become more complicated and this ethical issue is but only one of the Catch-22 ethical situations that will continue to confront physicians.

I have great faith in the integrity and capability of physicians and our profession, and I am sure that we will solve these dilemmas to the benefit of our patients and society.

It certainly was simple just to rake and burn the leaves.□

By Fred W. Bryant,

A bioethical bill of rights?



Bryant

The MSMS Committee on Bioethics presents this Special Report, taken in part from the Committee's Annual Scientific Meeting presentation, "Bioethics: From Here to Eternity."

Bioethics, the sum aggregate of human attitudes in relation to the conduct of health activities, is a concern for life. If we were to compose a bioethical biography, a bill of rights to serve as a guide to proper decorum, freedom of choice would be the first Article. In the best style and spirit of the founding fathers it falls into the "unalienable" or "we hold these truths to be self-evident" category. The individual almost invariably has the right to make autonomous health decisions.

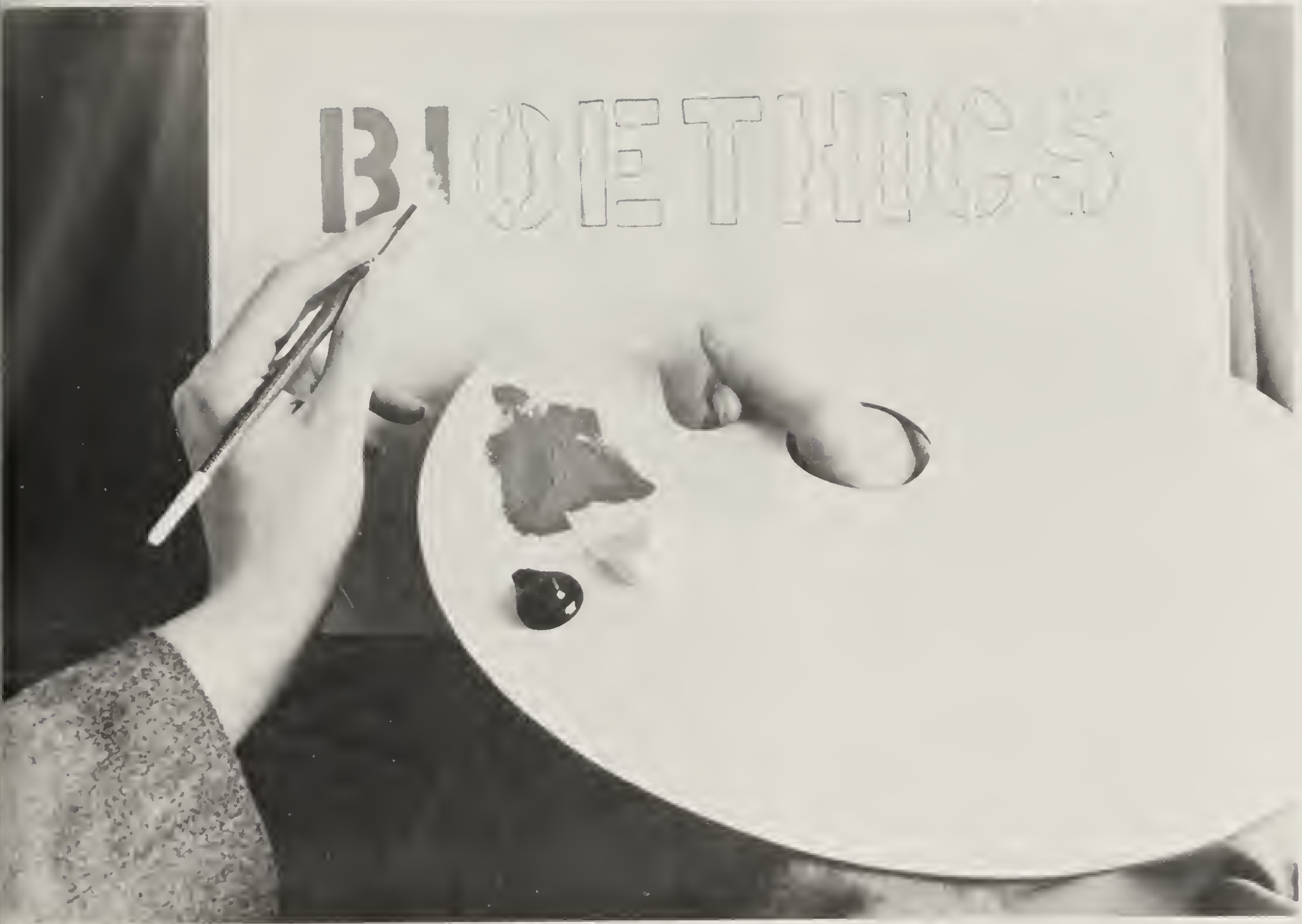
A close corollary is the right to know, the presumption being that an able citizen imbued with the facts is in the ideal position to act in his own best interest, and thus give informed consent. Alas, even possessed of all the facts, some fail to make prudent choices. In that case the injudicious individual apparently retains the right to make his own moves and mistakes, to amuse and abuse (overeating, using cigarettes, alcohol and a variety of jaded drugs) or to refuse (food, IVs, blood and medicines) and lose, even if death may result.

And when a person is truly incompetent, what authority prevails? Perhaps a paper, prepared in advance, indicating a course of action to apply when the individual cannot think clearly or speak for himself. Such documents as the living will and durable power of attorney exemplify this approach, but have not yet been thoroughly tested medicolegally. In most cases the next of kin speaks for the afflicted. Occasionally, perhaps when family members disagree, make controversial decisions, or no
family can be found, the co
may be called upon to reso
the issue.

The extremes of mortal e
tence, birth and death, have
traditionally been areas of i
tense bioethical interest.
Recognizing the helplessnes
and dependency attendant
upon these precarious event
we ask "what can we do,
what's right, where is the
limit?" When does a pregna
woman surrender exclusive
jurisdiction of her body and
share responsibility for her
temporary tenant? When, pr
cisely, does death occur, re
dering further treatment futi
What is the cost, who pays,
who receives?

Nowadays a biological an
bioethical "big bang" has e
ploded beyond the boundari
of natural life spilling into n
worlds of controversy and c
jecture. Everything from in-vitro fertilization, surrogate
housing and DNA tampering
whole-organ transplants,
prosthetic pumps and botto
line brain death. And from
cryopreservation of sperm t
cryopreservation of corpses.
To all this, societal sentimen
is, in the main, benign and
blasé, hardening to overrule
dividual prerogatives rarely i
exceptional circumstances.☐

Doctor Bryant, Royal Oak, ophthalmologist, is chairman, MSMS Committee on Bioethics, and is a member of the MSMS Board of Directors.



By William B. Weil, Jr., MD

he aftermath of Baby Doe
n the US

early 1982, a male infant
as born in Bloomington, In-
ıa with Trisomy 21 (Down
drome) and a tracheoesoph-
al fistula. Surgery to cor-
the fistula was refused by
parents with the physician
curring. The child was una-
to be fed because of the anomaly of the esophagus and died a short time later. In the interim the parental decision was upheld by a circuit court and the supreme court of Indiana refused to intervene.

When this death became known to the federal government, a series of actions was undertaken to attempt to prevent any further occurrences of such events. These actions were based on the government's interpretation of a 1973 law, a section of which (504) invokes federal penalties for discrimination on the basis of an individual's handicap.

In a prolonged series of political, legal and ethical confrontations over the basis of the federal actions, the manner in which these actions were to be carried out and the manner in which they were proposed, two factions arose within the American public. The faction endorsing the government's position included the right-to-life or anti-abortion movement, those organizations representing handicapped persons such as the Down Syndrome Congress and the Association for Retarded Citizens, and many others with a conservative po-

Continued on next page

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tor Weil is a professor, MSU
lege of Human Medicine, De-
tment of Pediatrics/Human De-
opment. He was course director
"Bioethics — From Here to
nity: Part I" at the MSMS An-
l Scientific Meeting.

BABY DOE/Continued

litical orientation. The opposition faction consisted primarily of medical organizations, proponents of the pro-abortion or prochoice group and various public figures of a liberal political persuasion.

In June of this year, the United States Supreme Court rejected the government's case on several grounds but primarily on the basis that the hospitals were not discriminating against handicapped infants who were being allowed to die, because the hospitals and their medical staff were only following the requests of the parents of the children. Thus there was no basis for any alleged discrimination.

But all of this took four years to accomplish and in the interim many things had changed. In 1984 the Congress of the United States amended the basic child abuse and neglect law to add the concept of medical neglect as applied to the care of disabled newborns. After much debate and modification of the regulations interpreting the new law, it went into effect in October, 1985 and is now the basic law designed to protect the interests of the newborn infant with disabilities.

New amendments

The new child abuse amendments require the individual state child abuse and neglect agencies to provide mechanisms for intervening in the care of a handicapped infant if the parents refuse to allow a procedure that may be medically indicated in the care of the infant, regardless of whether the doctors support or oppose the treatment:

(1) When the infant is chronically and irreversibly comatose.

(2) When treatment would merely prolong dying, not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or otherwise be futile in terms of the survival of the infant.

(3) When the treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane.

The regulations interpreting the new amendments also encouraged the formation of hospital committees to review prospectively, cases of proposed withdrawal or withholding of care for handicapped infants.

What has been the outcome of all this political and ethical jousting? If one reads what has been published in the United States in the past 18 months on this topic, one could conclude any of the following:

(1) Every effort must be made to keep every baby alive as long as possible or the same babies are being treated intensively today as were treated intensively five years ago.

(2) Parents have been reinstated as the major decision-makers for their newborn infants or parents are no longer able to decide when to treat or not to treat their own babies.

(3) The practice of neonatology has been taken over and is in the process of being destroyed or no detectable systematic
change in nursery prac-
tices has occurred in th
past two years as in ou
growth of the Baby Do
laws.

Is there any way to get t
the truth? The answer is "n
yet." It is likely that the tr
lies somewhere in between
extremes just mentioned.
However, there are several
quelae to the Baby Doe de
that are reasonable to
postulate:

(1) One group of events ca
be collectively labelled
"Increased Awareness."
There seems little doub
that both public and
professional groups and
dividuals are much mor
aware of, and more
thoughtful about, a vari
of important questions:

(A) Is there any mora
basis for allowing any n
born to die when a trea
ment is available that
might prevent or delay
death? If so, what are th
criteria for such action?
How does one determin
they apply to a particula
infant and who makes th
decision?

(B) Should quality of
impact on the decision
treat or not treat? What
should form the basis of
quality of life judgment?
Whose view of quality o
life should predominate?

As one outgrowth of these
questions, there is an increa

eptance of the concept that
sons of all ages with disa-
ies have an intrinsic value
ivalent to that of a person
out disabilities. The in-
ased valuing of persons
h disabilities has improved
status of millions of US
zens, and that is certainly a
tory utilitarian outcome.
oth the public and the med-
community have also be-
ne increasingly cognizant of
fundamental uncertainties
racteristic of medical diag-
is, treatment and prognosis.
shared acknowledgement
uncertainty by the physician
the patient's family, when
t becomes common, is
ly to improve the basic
ient-doctor relationship.

ctice changes

nother group of outcomes
ich has arisen from the Baby
e dispute and its current
islative resolution is related
changes in the practice of
natology. In this arena, one
ds to distinguish between
outcomes that evolved
m the actual regulations and
se outcomes that are evolv-
on the basis of the
ysician-perceptions of the
ulations.
ne of the real as well as
e of the perceived outcomes
that physicians are no longer
only overseers of the in-
ests of the infant. In the
st, if the physician disagreed
h a parental decision, the
ysician had access to the
urts, as they still do.
wever, if the physician
reed with the parental deci-
n, that was all that was re-
ired and the infant lived or
d on the basis of the par-
ts' and physicians' joint deci-
n. That is no longer the
se. Today, even if the physi-
n agrees that the parents'
cision to withhold or with-
aw treatment is a sound one,
at decision could be re-
ewed by a hospital commit-
, a government agency and
judicial system of the
ate. Furthermore, the deci-
sion could be overturned by the courts. I believe that this dethroning of the final arbiter role of the physician is what has created much of the medical antipathy to the new regulations. It is rare for any group to lose power gracefully and physicians as a group are no exception.

A real outcome to the regulations that is also beginning to be a percieved one, is that Infant Bioethics Committees, or Infant Care Review Committees, as the regulations refer to them, will play an increasingly important role in reviewing prospectively the potential decisions to withhold or withdraw life-sustaining treatment for infants with disabilities. To date this has been reflected by the increasing number of hospitals that have formed or are forming such committees. It seems clear that many of the procedures adopted by the individual states give the child abuse and neglect agencies considerable discretion in accepting hospital committee reviews of treatment/no treatment decisions as definitive. However, at this time there still are no data on how the state agencies are actually going to respond to committee decisions as there appear to have been too few cases to have reached such a point for any study to have been accomplished.

One outcome of the political process, as perceived by the author but by few practicing neonatologists, is that the three exceptions to the treatment mandate are sufficiently broad as to encompass almost all of the situations in which a physician would actually agree, on an ethical basis, to withholding or withdrawing life-sustaining treatment. Obviously, this position ultimately will need to be tested at the level of judicial review but it may be quite some time before that occurs.

Other reactions

By way of contrast, it would appear that a large number of neonatologists perceive the final denouement of the Baby Doe affair quite differently. These individuals appear to be treating many infants who are dying, or who would otherwise meet the exception criteria, with more vigor than may be warranted. There also appears to be great reluctance to withhold or withdraw treatment in the face of an apparently hopeless prognosis. Several explanations suggest themselves as the basis for these apparent behaviors.

One explanation may be that as a result of a misunderstanding of the regulations, or as a

Continued on next page

BABY DOE/Continued

result of the fear of possible legal action, whether warranted or unwarranted, the physician feels compelled to treat infants that he or she would otherwise be inclined to allow to die. The fear of legal action is consistent with the current litiginous environment surrounding medical practice in the United States.

Another explanation for the perceived increase in treatment of newborns with disabilities is that there were, in fact, infants who did not receive appropriate treatment in the past and comparably affected infants now are receiving treatment which is presently deemed necessary. If this were the case, the new regulations would be instrumental in saving lives that otherwise would have been lost. Again we have no data whatsoever to support this hypothesis.

An alternative explanation for some of the reported increase in treatment is that it• has occurred only in the perceptions of the neonatologists but actually has not taken place. The basis for this false perception, if it has occurred, is that there has always been a strong tendency on the part of physicians, as an integral aspect of the medical culture, to treat vigorously the dying patient. In the past, much of this almost fruitless striving against death has been rationalized on a variety of bases ranging from inability to cope with mortality as an individual problem, to the effect of the socialization process inherent in medical education, a socialization that does not accept death as a reasonable outcome.

Whatever the rationalization utilized for excessive treatment, the result was a mixture of feelings of uneasiness, guilt and regret by the physician, especially when the outcome failed to justify the intervention. Derivative from these feelings was a tendency to repress, or at least not openly discuss, these occurrences. If this hypothetical analysis were correct, it could follow that physicians still are doing what they have always done. The difference now is that there is a ready location to place the onus for these behaviors.

The new laws can be blamed for the doctor's inherent need to treat even when such treatment may no longer be in the interests of the patient. Not only would it now be possible to discuss such behaviors more openly but one could, at the same time, be able to fault what has been viewed by m as an unacceptable governm tal intrusion into the physician's domain. Thus there would now be good reason emphasize behavior that pr ously had been functionally under-reported. Out of this change in revealing what is happening could come the ception that unwarranted o treatment has increased as result of the ramifications o the Baby Doe affair.

Sorting it out

Whether any, all, or some these explanations for what perceived as the aftermath Baby Doe are valid remains conjectural. It will undoubte require time, data and an historical perspective to so out the perceptions of reali itself and to attribute whate changes may have occurred the appropriate explanation

In summary, the death of Bloomington, Indiana Baby has generated a four year p litical and ethical controver that, while temporarily settl at the political level, has le many ethical questions unan swered. In addition there ha been increased public and professional awareness of t many issues involved in the withholding or withdrawing life support treatment. Ther have also been several mor tangible outcomes such as increased use of hospital bi ethics committees, the imposition of a social revie system on the decision-maki process of patients, families and physicians and, at least, the perception that overtrea ment of futile situations has creased. Whether these outcomes are socially valuable, whether they are what was i tended when the process be gan and whether individual tients have been helped or harmed remain to be determined, but these, then, represent the aftermath of Baby Doe in the United States.□

SPECIAL REPORT

By Howard Brody, MD

lpdate: Terminal care decisions in Michigan

reatment decisions at or near the end of life remain ong the most vexing ethical blems facing physicians. In ME course at the 1986 MS Annual Scientific Meet- , Michigan physicians eived updates in three areas tinent to terminal care deci- ns: "living will" or advance ective legislation; recent rt opinions on withdrawing atment; and required re- est for organ donation.

ichigan is among the ority of states that has ther passed legislation for- lizing the process of allow- patients to execute ad- ce directives, nor perienced a high-court deci- n setting a precedent for cumstances in which life- longing care can be with- wn. David Wiener, aide to . David Hollister, and Brad ller, aide to Rep. Perry Bul- d, addressed two bills cur- tly before the Michigan use, HB 4883 (revision of able power of attorney to ver medical decisions) and 5286 (providing for an in- uction document or so- led "living will" to be used he patient later becomes incompetent). Neither will be acted upon in the 1986 session, but both will be reintroduced next year and efforts are underway to amend the language so as to respond to current criticisms. To the objection that there is no real need for such legislation, and data to suggest that only a small minority of patients will make use of these mechanisms, Wiener and Geller responded that both legislators' mail and in-state opinion surveys show a vast degree of public support, and that increased numbers of patients will use such mechanisms following appropriate public education.

Bruce Miller, PhD, of Michigan State University's Department of Philosophy surveyed major court decisions in other states from the 1976 Quinlan ruling to the 1986 Brophy case. He characterized a common thread that tends to run through all such decisions—that competent patients have a right to refuse any and all medical treatment, and this right, while not absolute and unqualified, nevertheless does not disappear once the patient becomes incompetent, so long as a proxy can be identified to decide on the patient's behalf. No case in the US has provided a basis for saying that a physician faces legal liability for withdrawing life-sustaining treatment at the request of the patient or the family.

If Michigan law has lagged in some areas, it has marched ahead in requiring (as of October 7) that hospital personnel must ask the families of all potential organ donors whether or not they are willing to donate. Martin Benjamin, PhD, professor of philosophy at Michigan State University and chair of the committee on social and ethical issues of the Michigan Transplant Policy Center, characterized this policy of required request (enacted so far by 27 states) as being an ethical middle ground between two extremes—the present policy of "encouraged volunteerism" which yields far too few organs for transplant; and a more aggresive policy of presumed consent which most would find unduly intrusive. The biggest barrier to organ transplant, in Benjamin's opinion, is the lack of understanding of the meaning of brain death among the public, fed by misleading press reports and sometimes reinforced by poor choice of words by physicians and hospital personnel. Once everyone understands that "brain dead means dead," argued Benjamin, there will be fewer refusals of donation.

The course during which this material was presented, "Bioethics—From here to eternity: Part 3" was one of three coordinated by Thomas E. Elkins, MD, professor of obstetrics and gynecology, University of Michigan.☐

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ctor Brody, professor at the U College of Human Medicine, artment of Family Practice, course director for "Bio- ics—From here to eternity: Part at the 1986 MSMS Annual entific Meeting.

AMA broadens opinion on life-prolonging treatment

The AMA's Council on Ethical and Judicial Affairs has broadened its opinion on withholding or withdrawing life-prolonging medical treatment to include medical and artificially or technologically supplied respiration, nutrition or hydration.

The new opinion is expected to command prominent attention by the national news media because of mounting societal concern about questions relating to the treatment of the terminally ill or irreversibly comatose patient, including serious economic considerations. Here is the new opinion:

- The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the choice of the patient, or his family or legal representative if the patient is incompetent to act in his own behalf, should prevail. In the absence of the patient's choice or an authorized proxy, the physician must act in the best interest of the patient.
- For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to permit a terminally ill patient whose death is imminent to die. However, he should not intentionally cause death. In deciding whether the administration of potentially life-prolonging medical treatment is in the best interest of the patient who is incompetent t act in his own behalf, the physician should determine what the possibility is for extending life under humane and comfortable conditions and what are the prior expressed wishes of the patie and attitudes of the family or those who have responsibility for the custody of the patient
- Even if death is not imminent but a patient's com is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis and with the concurrence of those who have responsibility for th care of the patient, it is not unethical to discontinue all means of life-prolonging medical treatment.
- Life-prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration. In treating a terminally ill or irreversibly comatose patient, the physician should determin whether the benefits of treatment outweigh its burdens. At all times, the dignity of the patient should be maintained.☐

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CHICAGO!

By Sheri W. Greenh
Managing Edi

Call MSMS, not the Blues, about your group health insurance

After January 1, 1987, physicians who subscribe to MSMS health care insurance programs should direct benefit-related inquiries to MSMS rather than to Blue Cross Blue Shield. As of that date, Physician Service Group, Inc., an MSMS subsidiary, will be online under an "administrative services only" (ASO) contract with the Blues to manage physician subscribers' policies.

The MSMS Board of Directors approved the ASO arrangement in July as proposed by expert pension consultants Miller, Mason and Dickenson, Inc. At the same time, the Board created the Michigan State Medical Society Group Health Insurance Trust, and elected these Trustees: MSMS Assistant Treasurer and Finance Committee Chairman Jack Barry, MD, Trust chairman; MSMS Treasurer Leland E. Holly, II, MD; MSMS Task Force to Review Member Insurance Benefit Programs Chairman B. David Wilson, MD, and MSMS Executive Director Bruce Ambrose.

The trustees eventually will evaluate all MSMS group insurance programs including life, disability, workers' compensation and office overhead. But improved health insurance for physicians and their employees is their first project, said Doctor Barry.

The Trust, which funded the establishment of the ASO, was created with monies returned to MSMS by BCBS in accordance with a new federal law which requires the return of residual premium dollars to the insured.

The Trustees gave the pension consultants the go-ahead to develop a program to not only service MSMS members' health insurance benefits, but those of all MD groups in the BCBS pool. While those other groups won't be serviced at the outset of January 1, they will be phased-in during 1987.

MSMS members will enjoy several advantages under the new arrangement, according to John Richards, general manager of MSMS subsidiary operations. "The physician will be better served, in that the people doctors will call to inquire about coverage will be employees of MSMS, and therefore more in tune with physicians' needs."

Physicians insured through MSMS group plans should call this toll-free number at MSMS headquarters after January 1 with questions, comments or complaints: 1-800-942-4141.

Improved access

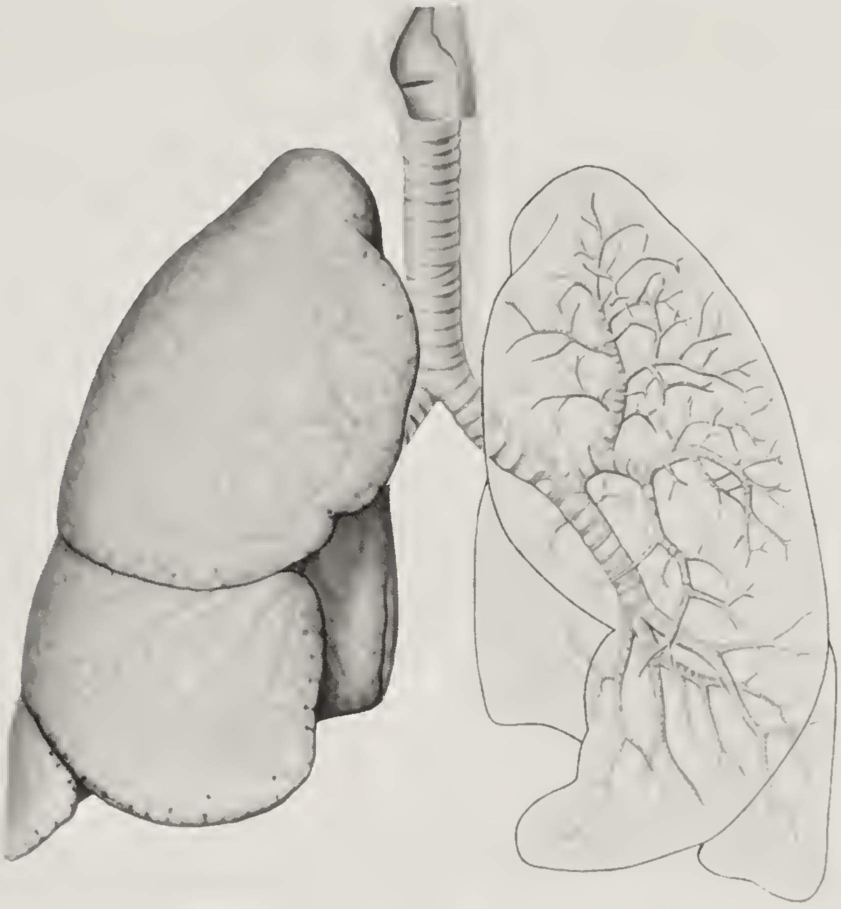
The ASO contract will allow MSMS to study and improve all health benefits offered to members, Richards said. "We will now have access to the numbers and logic that creat insurance rates. With that information, MSMS will be in a position to knowingly discus rates with Blue Cross Blue Shield. We will be able, then through our consultants, to negotiate much better rates our members."

MSMS already has had som success in that endeavor, sai Doctor Barry. Recent premiur increases were held to 21 pe cent — a much smaller increase than originally propos by the Blues — because of th MSMS arrangement to marke administer and service physician insurance programs.

"For a time, MDs in certain geographic areas could get a lower insurance rate than the could through MSMS by forming small groups," Richards said. That will no longer be t case, because Blue Cross Blue Shield has agreed that, by blending the rates of all groups, MSMS-serviced group insurance plans will carry the lowest price tags available in Michigan.

Once physician-serviced plans are up and running, all medical assistants' insurance coverage in the state will be serviced by MSMS, and those rates will be guaranteed lowe as well.□

Consider the causative organisms…



Ceclor®
cefaclor

250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
(ampicillin-susceptible) (ampicillin-resistant)

Brief Summary Consult the package literature for prescribing information

Indications and Usage Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy appropriate bacteriologic studies and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by C *difficile* Other causes of colitis should be ruled out

Precautions *General Precautions* – If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and if necessary, the patient should be treated with appropriate agents e g pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy – Pregnancy Category B – Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor® (cefaclor, Lilly) There are however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers – Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0 18, 0 20, 0 21, and 0 16 mcg/ml at two, three, four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children – Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and frequently, fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain – Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology they are listed below to serve as alerting information for the physician

Hepatic – Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic – Transient fluctuations in leukocyte count predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal – Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[061782R]

Note Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections including the prophylaxis of rheumatic fever See prescribing information

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Additional information available to the profession on request from
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Eli Lilly Industries, Inc
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By Deborah Zannoth

Highlights of the Omnibus Budget Reconciliation Act

The recently enacted Omnibus Reconciliation Act (OBRA) of 1986, P.L. 99-509, affects physicians, hospitals, Medicare carriers and PROs. Although this article is not a complete analysis of the 150 changes in the Medicare program, it is a useful summary of the legislation.

OBRA contains a significant number of changes regarding physician payment. All physicians (both participating and non-participating) will receive an equal update of 3.2 percent in Medicare prevailing charges beginning January 1, 1987. Non-participating physicians will receive 96 percent of the amount allowed participating physicians as actual reimbursement. The current freeze on actual charges of non-participating physicians expires on December 31, 1986, and is replaced by a system of charge limitations.

This system is outlined below:

If the physician's actual charge for any given service is at or above 115 percent of the prevailing charge (to be determined each year) the actual charge for the service may be increased by no more than one percent.

If the actual charge is less than 115 percent of the prevailing charge, that charge may be increased by the greater of one percent or as follows:

- January 1, 1987—charge increases are limited to one fourth of the difference between the actual charge and 115 percent of the Medicare prevailing charge;
- January 1, 1988—charge increases are limited to one third of the difference between the actual charge and 115 percent of the Medicare prevailing charge;
- January 1, 1989—charge increases are limited to one half of the difference between the actual charge and 115 percent of the Medicare prevailing charge; and
- January 1, 1990 and subsequent years—actual charges may be increased to 115 percent of the Medicare prevailing charge.

Medicare carriers are required at the beginning of each year to provide each non-participating physician with a list of his or her maximum allowable actual charges for the year.

The Secretary of Health & Human Services, using inherent reasonableness procedures, must review the ten most costly Medicare procedures and establish payment levels for a physician service based on considerations other than actual, customary or prevailing.

Physicians must decide by January 1, 1987, whether they wish to participate and indicate their choice to the Medicare carrier in writing by that date. Directories listing participating physicians will be available at no charge.

Physicians who do not accept assignment for elective surgery over $500 are required to reveal to the patient their actual charges. This must be in writing on a form approved by the Secretary of Health and Human Services. This form will include the Medicare allowed amount, the patient's deductible and coinsurance liability and the physician's excess charge. Physicians may have to make a refund to the beneficiary where disclosures are not made. This regulation will take effect October 1, 1987.

Mandated assignment for clinical lab services in a physician's office will take effect January 1, 1987.

Hospitals will have a copy of the participating physician directory and will make this available to patients.

Carriers affected

Medicare carriers are also affected by the legislation. The provisions call for programs to encourage physician participation, require prompt payment of clean claims and must begin paying interest on delayed claims (interest starts sooner for participating physicians). The carrier will receive a cash bonus based on increased physician participation.

Other entities affected by OBRA include hospitals, PROs and several ancillary health professionals. *Medigram* will carry a more detailed analysis of OBRA and its effects in the near future. ☐

Ms. Zannoth is assistant, MSMS Department of Finance, Medical Economics and Physician/Hospital Relations.

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By Thomas J. DeKornfeld,

'Tis the season to tally your CME credits

DeKornfeld

This column is devoted to a serious issue: the continuing medical education (CME) requirements mandated by the Public Health Code and the duty imposed upon the Board to monitor compliance.

In my last column I made reference to the fact that each license renewal card has a signature line where the applicant attests that he or she has completed the CME requirements and has complied with the regulations.

The Code and the Rules of the Board require that every physician obtain 150 hours of CME credits during the three calendar years immediately preceeding the renewal application. Thus, those who have to renew this year (by January 31, 1987) must have obtained the required 150 hours during calendar years 1984-1985 and 1986.

As you undoubtedly realize, the requirements further stipulate that no less than 75 hours of this total number of hours must be in Category 1, i.e. must be obtained by attending an approved CME program (lecture, conference, symposium). The remaining 75 hours may be a composite of categories 2-5. Briefly: Category 2 is CME activity with non-accredited sponsorship (maximum 36 hours in three years); Category 3 is defined as formal teaching to physicians and to other health care personnel (maximum 48 hours in three years); Category 4 is scholarly activity, i.e. refereed publications, books, etc. (maximum 48 hours in three years); Category 5 is nonsupervised education (maximum 36 hours in three years). Category 6 is formal postgraduate training in an approved training program of at least five months in any calendar year. This, incidentally, is the only activity which can be used in lieu of Category 1 credit.

It is a further requirement that each licensee maintain a record of CME activity for at least four years and present it to the Board on request.

Since at the present time it is not possible to audit every applicant for license renewal, the Board has decided to conduct a random audit of approximately 10 percent of the applicants. This is an actuarially sound sample size and should provide valid information co cerning compliance.

Audit notices

Since approximately 7,000 medical licenses are renewe each year, about 700 "lucky people" can expect to recei an notice of a CME audit so time after the first of the ye This notice will be sent to th same address as the renewal application and will thus be considered a valid address, since the renewal applicatio had been sent to the same a dress and had elicited a response in the form of a renewal card. Each audited physician will then have thirt days to submit evidence to t Board that he or she had co plied with the CE requiremen For Categories 1,2,3,4 and 6 the documentation has to be the form of a certificate of a tendance, a journal or book reference, evidence of teach ing activity or evidence of fu time participation in formal postgraduate training. For Category 5, and for Category only, we will be pleased to take your word.

Hopefully, you will have n difficulty in providing the required documentation and w will be prompt in returning it to the Board. If you have mis placed the CME certificates you should be able to get co pies or a statement from the sponsor verifying your atten-

Continued on page 6

Doctor DeKornfeld is administrator, Michigan Board of Medicine.

Rhe's counting on You

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dance. If you find that you a few hours short, you should have no difficulty in making this up during the thirty days within which you must respond.

The time of audit is not the time to ask for a waiver from the CME requirements. This must be done at the time the renewal application is filed. Even at that time, waiver can be granted by the Board for three reasons only: absence from the US, service in the armed forces or physical disability. In order to qualify for the physical disability waiver, it is necessary to submit a certificate from your own physician indicating the nature of the disability, its severity and probable duration. If this waiver request is made in a timely fashion, the Board will grant the waiver, but will also consider the likelihood of your being able to continue to practice in a safe and competent manner. In other words, if the Board comes to the conclusion that you are unlikely to resume active practice it may recommend that you either not renew your license or that you request a reclassification to a "retiree's limited license."

Please, do remember that by signing the renewal application, you have attested to the Board that you have met the CME requirements. You obviously cannot do this and then come back a month later and ask for a waiver for not having done something that you had just claimed to have done. While this last sentence may not be in the same lapidary style as my usual utterances, I sincerely hope that you will nevertheless "get the message."

One question remains. Wha is the Board going to do with those who will not respond o who, in spite of having filed renewal application, cannot document the 150 hours of CME? I don't wish to cast eve a tiny shadow over the upcoming holiday season, but I mus tell you that the Board is taking its responsibilities very seriously indeed and that it may start disciplinary proceedings against each and every physician who has not met hi or her CME requirements.

This is the last column for 1986. I would again like to invite your comments and suggestions, and I do want to ta this opportunity to wish all o you a merry and blessed holiday season and a happy, healthy and CME-ful new year.☐

Best Wishes
for a
Joyous
Holiday Season

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☐ Wednesday, December 10

Orlando, FL:
☐ Friday, December 12

Atlanta, GA:
☐ Wednesday, December 3

Chicago, IL (AMA):
☐ Thursday, November 6
☐ Wednesday, December 10
☐ Friday, January 16

New Orleans, LA:
☐ Wednesday, December 10

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☐ Wednesday, November 12
☐ Friday, January 23

Dearborn, MI:
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Board of Medicine Actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: Michael A. Marshall, MD
Action, Date taken: Summary Suspension, September 17, 1986
Reason: Continued licensure constitutes an imminent threat to the public health, safety and welfare requiring emergency action.

Name: Rolando Mateo, MD
Action, Date taken: Suspende one (1) year, September 18, 1986
Reason: Circuit Court for the County of Wayne dissolved th stay of enforcement of the Board's Order previously entered on December 10, 1985.

Name: Michael S. Quadir, MD
Action, Date taken: Revoked, September 17, 1986
Reason: Violation of general duty; failed to conform to minimal standards of acceptable and prevailing practice; sells, prescribes, gives away administers drugs for other than lawful diagnostic or therapeutic purposes; violation of a rule promulgated by the Board.

"Of course Dr. Klingman makes house calls. What's your phone number?"

CONTROL
ACID RAIN
with once-a-night
h.s. therapy for active
duodenal ulcers

Only one tablet at bedtime

Controls nocturnal acid to relieve pain and heal duodenal ulcers

Heals active duodenal ulcers after 4 weeks in most patients*[1]

ZANTAC 300 mg h.s.	270/320	84%
ZANTAC 150 mg b.i.d.	292/345	85%

In well-controlled, double-blind, multicenter trials, ZANTAC 300 mg h.s. healed active duodenal ulcers in 84% of patients after 4 weeks. After 8 weeks, healing rates may be higher with ZANTAC 150 mg b.i.d. (92%) than with ZANTAC 300 mg h.s. (87%).

Relieves pain and other symptoms as effectively as ZANTAC 150 mg b.i.d.[1]

Zantac® 300

ranitidine HCl/Glaxo 300 mg tablets

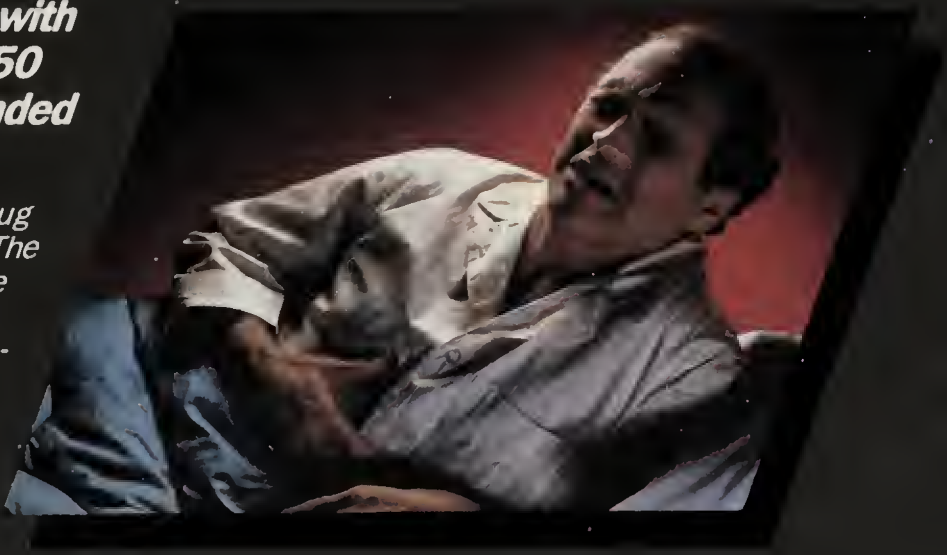
Once-daily dosing may enhance compliance in patients for whom dosing convenience is important

Side-effects profile comparable to ZANTAC 150 mg b.i.d.[1-3]

Headache—sometimes severe—has been reported. Rare effects on the CNS, cardiovascular, GI, hepatic, and integumental systems have been observed, as well as rare cases of hypersensitivity reactions. See ADVERSE REACTIONS section of Brief Summary of Product Information before prescribing.

No significant interference with the hepatic cytochrome P-450 enzyme system at recommended doses

ZANTAC 300 mg h.s. had no significant drug interactions with theophylline or warfarin. The bioavailability of certain medications whose absorption is dependent on a low gastric pH nay be altered when ZANTAC or other medica- ons which decrease gastric acidity are lministered.



s not known exactly how much acid inhibition eeded to heal ulcers.

Glaxo/ROCHE

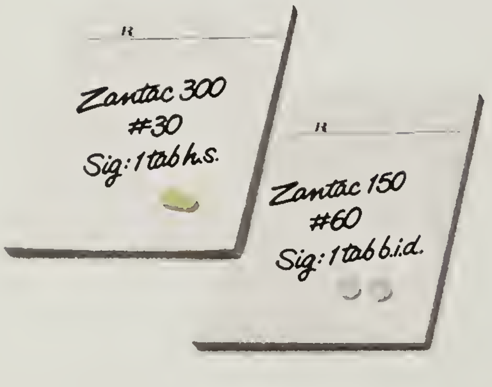
See next page for references and Brief Summary of Product Information.

IN ACTIVE DUODENAL ULCERS

Once-a-night h.s. therapy controls acid rain

Zantac® 300
ranitidine HCl/Glaxo 300 mg tablets

Two effective regimens to treat active duodenal ulcers:



References: 1. Data available on request, Glaxo Inc. **2.** Ireland A, Colin-Jones DG, Gear P, et al: Ranitidine 150 mg twice daily vs 300 mg nightly in treatment of duodenal ulcers. *Lancet* 1984;2:274-275. **3.** Colin-Jones DG, Ireland A, Gear P, et al: Reducing overnight secretion of acid to heal duodenal ulcers. *Am J Med* 1984; 77 (suppl 5B):116-122.

ZANTAC™ 150 Tablets
(ranitidine hydrochloride)
ZANTAC™ 300 Tablets
(ranitidine hydrochloride)

BRIEF SUMMARY OF PRODUCT INFORMATION

See complete product information before prescribing. The following is a brief summary

INDICATIONS AND USAGE: ZANTAC™ is indicated in:
1. Short-term treatment of **active duodenal ulcer**. Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer**. Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD)**. Symptomatic relief commonly occurs within one or two weeks after starting therapy. Therapy for longer than six weeks has not been studied.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: ZANTAC™ is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: General: 1. Symptomatic response to ZANTAC™ therapy does not preclude the presence of gastric malignancy. 2. Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function. Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during ZANTAC therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although ZANTAC has been reported to bind weakly to cytochrome P-450 in vitro, recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at doses up to 2,000 mg/kg/day.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, E coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next nine weeks.

Pregnancy: ***Teratogenic Effects: Pregnancy Category B:*** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ZANTAC. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: ZANTAC is secreted in human milk. Caution should be exercised when ZANTAC is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age groups.

ADVERSE REACTIONS: The following have been reported as ev
in clinical trials or in the routine management of patients trea
with oral ZANTAC™. The relationship to ZANTAC therapy has b
unclear in many cases. Headache, sometimes severe, seems t
related to ZANTAC administration.
Central Nervous System: Rarely, malaise, dizziness, somnole
insomnia, and vertigo. Rare cases of reversible mental confus
agitation, depression, and hallucinations have been reported,
dominantly in severely ill elderly patients.
Cardiovascular: Rare reports of tachycardia, bradycardia, and
mature ventricular beats.
Gastrointestinal: Constipation, diarrhea, nausea/vomiting,
abdominal discomfort/pain.
Hepatic: In normal volunteers, SGPT values were increased t
least twice the pretreatment levels in 6 of 12 subjects recei
100 mg qid IV for seven days, and in 4 of 24 subjects recei
50 mg qid IV for five days. With oral administration there
been occasional reports of reversible hepatitis, hepatocellul
hepatocanalicular or mixed, with or without jaundice.
Musculoskeletal: Rare reports of arthralgias.
Hematologic: Rare reports of reversible leukopenia, granulo
topenia, thrombocytopenia, and pancytopenia.
Endocrine: Controlled studies in animals and man have show
stimulation of any pituitary hormone by ZANTAC and no antian
genic activity, and cimetidine-induced gynecomastia and im
tence in hypersecretory patients have resolved when ZANTAC
been substituted. However, occasional cases of gynecomas
impotence, and loss of libido have been reported in male pati
receiving ZANTAC, but the incidence did not differ from that in
general population.
Integumental: Rash, including rare cases suggestive of mild
thema multiforme, and, rarely, alopecia.
Other: Rare cases of hypersensitivity reactions (eg, bronchospa
fever, rash, eosinophilia) and small increases in serum creatin

DOSAGE AND ADMINISTRATION: Active Duodenal Ulcer: The cur
recommended adult oral dosage is 150 mg twice daily. An al
nate dosage of 300 mg once daily at bedtime can be used
patients in whom dosing convenience is important. The adv
tages of one treatment regimen compared to the other in a part
lar patient population have yet to be demonstrated.
Maintenance Therapy: The current recommended adult oral dos
is 150 mg at bedtime.
Pathological Hypersecretory Conditions (such as Zollinger-Elli
Syndrome): The current recommended adult oral dosage is 150
twice a day. In some patients it may be necessary to admini
ZANTAC™ 150-mg doses more frequently. Doses should be adjus
to individual patient needs, and should continue as long as cl
cally indicated. Doses up to 6 g/day have been employe
patients with severe disease.
Benign Gastric Ulcer: The current recommended adult oral dos
is 150 mg twice a day
GERD: The current recommended adult oral dosage is 150
twice a day.
See full prescribing information for dosage adjustment
patients with impaired renal function.

HOW SUPPLIED: ZANTAC™ 300 Tablets (ranitidine hydrochlo
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and unit dose packs of 100 tablets (NDC 0173-0393-47).
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150 mg of ranitidine) are white tablets embossed with "ZAN
150" on one side and "Glaxo" on the other. They are availabl
bottles of 60 tablets (NDC 0173-0344-42) and unit dose pack
100 tablets (NDC 0173-0344-47).
Store between 15° and 30°C (59° and 86°F) in a dry place. Prot
from light. Replace cap securely after each opening.

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September 19

1,150 physicians earned CME credit at the 1986 MSMS Annual Scientific Meeting

Watnick, MD, Plymouth, left, Catherine Nordby, MD, sse Pointe, center, register for rses during the November 13 conference at the Hyatt ency Dearborn. MSMS staff mber Joyce Crum, right, registed attendees for courses offer a total of 18 Category I dits.

vid R. Rovner, MD, right, chairn of the MSMS Committee on ntinuing Medical Education gramming, observes a course, pdate in Immunology/Allergy."

"Clinical Applications of Magnetic Resonance Imaging: Update" was one of 54 courses offered over the three days. Here William Martel, MD, course director, presents slides.

Continued on next page

Photos by Russ Marshall

The course, "Bioethics: From Here to Eternity, Part 1," encouraged participation in the form of role-playing. John W. Gillenfo, MD, Petoskey, above, takes part in a discussion about ethical problems during childhood and adolescence. Course director William Weil, MD, and Barbara Supanich, MD, Grayling, listen to him.

Toby Hoyen, MD, Birmingham, left, enjoys hearin Cynthia Montgomery, *Health Care Weekly Review* associate editor, right, play the role of a mother during the course discussion. The participatory fo mat was enhanced by a circular room set-up, below.

iversity of Michigan Medical
hool Dean Joseph Johnson, MD,
viewed and judged clinical
ster presentations Tuesday af-
noon. Doctor Johnson, right,
scusses an entry with Samuel
McMahon, MD, 1986 Scientific
eeting co-chairman, center, and
ed W. Bryant, MD, member,
SMS Committee on CME
ogramming, left.

Accurate Presurgical Localization
by Technetium-Thallium Subtracti

Doctor McMahon, left, congratulates the first place winners in the poster competition: Conrad Nagle, MD, center, and Donald C. Blake, MD, right, both of Beaumont Hospital, Royal Oak. The presentation was entitled "Accurate Presurgical Localization of Parathyroid Adenomas by Technetium-Thallium Subtraction Scintigraphy." The doctors received a blue ribbon and a cash award.

udi Ansbacher, MD, 1986 MSMS
nnual Scientific Meeting co-
hairman, left, enjoys a break in
aculty headquarters with David
. Rovner, MD, chairman of the
MSMS Committee on CME Pro-
gramming and former Scientific
Meeting chairman.

Dean

Honet

Oyen

Woods

Sumer Verma, MD, East Lansing, associate professor of psychiatry at MSU, and **Joseph Papsidero, MD**, East Lansing, recently organized a conference to detail a unique cross-cultural study of health care for the elderly. . . . **Robert J. Priest, MD**, gastroenterologist, Detroit, and **John W. Sigler, MD**, rheumatologist, Detroit, both Fellows of the ACP, were named Laureates of the Michigan Chapter of the American College of Physicians. . . . **George A. Dean, MD**, Southfield, was the runner-up in the 1986-87 Family Doctor of the Year contest sponsored by the American Academy of Family Physicians. In 1985 Doctor Dean was named Family Physician of the Year by the Michigan Academy of Family Physicians. . . . **Leroy C. Barry, MD**, has been elected president of the Saginaw County Medical Society. Other officers inclu **Robert Clowater, MD**, president-elect; **Ernie Balcue** **MD**, secretary, and **Tim Smit** **MD**, treasurer. . . . **Doctor an** **Mrs. Edward Stehouwer** and **Doctor and Mrs. George Wagoner**, all of Cadillac, returned recently from Villah mosa, Mexico, having partici pated in a short-term missio project devoted to medical, surgical and dental care. . . . **Harold C. Shafer, MD**, B City, received the Michigan Laureate Award of the Amer can College of Physicians at the annual meeting of the Michigan Chapter. . . . **Scott Woods, MD**, Saline, has bee given honorary status after more than 25 years as a sta physician at Saline Communi Hospital. . . . **George T. Buechle, MD**, Pinconning, is one of five new members of the Board of Directors of Ba Medical Center and Bay Heal Systems. . . . **Patricia Ann**

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D ey, MD, Detroit, a recent
duate of Wayne State Uni-
sity School of Medicine,
chosen as student dele-
e to the Michigan Acadamy
amily Practice Physicians in
2nd, 3rd and 4th years and
elected president of the
ily Practice Club. Doctor
D ey also was selected by
ssmates as a member of the
stigious Aesculapians Soci-
. . . **Lloyd J. Hooper, MD**,
gins Lake, was appointed as
ew member of the Gerrish-
gins Board of Education.
. **Joseph Cooper, MD**,
gor, and the late **Siraj**
nani, MD, were honored in
eremony which dedicated
th Haven Community Hospi-
s Intensive Care Unit to the
doctors in honor of their
sion and dedication" in
ating and advancing the life
port unit. . . . **David W.**
ose, MD, Detroit, was
ed Clinical Instructor of the
r by the Family Medical
ter's Family Practice residents of St. John Hospital.

. . . **William F. Chandler, MD**, Ann Arbor, has been elected to the Executive Committee of the Congress of Neurological Surgeons for a three-year term. Doctor Chandler is president of the Michigan Association of Neurological Surgeons. . . . **George J. Adler, MD**, Saginaw, recieved the Ronald L. Krome, MD, Meritorious Service Award at the 13th Michigan Chapter, American College of Emergency Physicians Scientific Assembly. . . . **Pat J. Kulpa, MD**, Grand Rapids, and **Robert D. Visscher, MD**, Grand Rapids, received Community Awards from the Central Association of Obstetricians and Gynecologists in Milwaukee, for their research on exercise and pregnancy. . . . **Kenneth D. McClatchey, MD**, Ann Arbor, recently assumed office as a governor of the College of American Pathologists (CAP). . . . **Herbert Hamel, MD**, St. Ignace, was elected president of the Loryce M. Dyer Memorial Hospice of Mackinac County. . . . **John J. Coury, MD**, Port Huron, was presented the Distinguished Professional Award by the Michigan Association of the Professions (MAP). MSMS President **Thomas R. Berglund, MD**, was presented the Professional Man of the Year Award by MAP, and Winifred Oyen, MD, Midland, was named president of the organization. . . . **Joseph C. Honet, MD**, Detroit, was the recipient of the 1986 Distiguished Clinician Award of the American Academy of Physical Medicine and Rehabilitation. . . . **Paul D. Croissant, MD**, Rochester, was recently elected treasurer of the Oakland County Medical Society; **Robert C. Arends, MD**, Troy, has been elected secretary; **John A. Ingold, MD**, Birmingham, has been elected president-elect, and **Michael Garcia, MD**, Bloomfield Hills, was installed as the new president.☐

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Physicians win 28 times during the 99th Congress

When Congress adjourned in October, the AMA and the entire medical profession were able to lay claim to notable successes resulting from their increasing involvement in the legislative process.

AMA's assessment revealed that the profession had either achieved victory or made its mark on 28 major issues during the 99th session.

These success demonstrate the broad scope of AMA's involvement in the legislative process that ensued during the 99th Congress. This article details which positions have either prevailed or will be under further consideration.

The record speaks for itself, but it also emphasizes the need for heightened involvement by the profession during the forthcoming 100th Session of Congress to effectively impact upon national health issues of concern to the profession and to the public.

Here are successes that occurred during the 99th Congress:

1. **Fee freeze**—The Medicare fee freeze for non-participating physicians has been ended.
2. **Medicare reimbursement**—Medicare reimbursement will be increased an equal percentage for participating and non-participating physicians.
3. **Health planning**—The federal health planning program has been repealed.
4. **Professional liability**—AMA-developed legislation to provide incentive grants for state tort reform was introduced in Congress with a number of co-sponsors and hearings in major committees.
5. **Doctor draft**—Legislation that would have established a health professions draft registration was defeated.
6. **CHAMPUS**—Implementation of a nationwide capitation system and competition contracting for CHAMPUS care was slowed. Instead, partial demonstration of this concept will be conducted.
7. **PAC limitations**—Amendments to inappropriatel limit PAC contributions were not enacted.
8. **Tobacco ad ban**—Major legislation was prepared and introduced in congressional hearings in support of a tobacco ad ban.
9. **Vaccine funding**—Legislation has passed the House that would provide increased funding for vaccine stockpiles held by the public

Continued on page 68

Mutual Memo

4

Fourth in a series

How clear hand-writing can reduce medical liability risk

TO: **Michigan Physicians**

FROM: **Loss Prevention, Underwriting and Claims Departments**

RE: **Preventing claims through legible handwriting**

One of the easiest ways to reduce your exposure to a professional liability claim is to write medical records clearly.

A recent study published by two physicians in the New England Journal of Medicine confirms that illegible medical records can be a source of professional liability risk.

The study revealed that illegible handwriting reduced reading comprehension of medical progress notes by physicians themselves in 42% of the records screened.

Illegible medical records can cause ancillary personnel to make medication mistakes and other errors that may lead to patient injury.

Take a minute to write medical records clearly and completely. It may reduce your medical liability risk. It can help save health professionals' time, and raise the quality of medical care even higher.

Insuring physicians and assisting them to identify and minimize medical liability risks is our business. Call us for information about our insurance and loss prevention services.

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health service (AMA supported such increased fundings in order to build up adequate stockpiles).

10. **Vaccine compensation**—A bill has passed the Congress that would, consistent with AMA's policy, establish a no-fault compensation system for individuals injured due to mandated pediatric vaccines.

11. **Peer review immunity**—Legislation has passed the Congress that would provide protection through anti-trust immunity for peer review activities taken by hospital credentialing committees and medical societies.

12. **Medicare appeals**—Appeals of Part B claims beyond the carrier's hearing officer have been authorized.

13. **Definition of physician**—Legislation was developed by the AMA and introduced in Congress to modify the Medicare definition of "physician" to include only Doctors of Medicine and Osteopathy. Medicare regulations were finalized that reversed a proposal that was inconsistent with AMA views on the appropriate use of the term "physician." The AMA views prevailed in the final regulation.

14. **Limited license practitioners**—Legislation that would have required FEHBP carriers to directly reimburse services of limited license practitioners has been stalled in the Senate and has not been adopted.

15. **Drug samples**—Legislation has been reported by the House Energy and Commerce Committee that would continue to allow distribution of drug samples by pharmaceutical representatives.

16. **Cigarette tax**—A rollback in the tobacco tax from .16 cents to .08 cents per pack of cigarettes was defeated.

17. **Alcoholic beverage tax**—An increase in the tax on alcoholic beverages was enacted.

18. **Graduate medical education funding**—Efforts to reduce Medicare funding for graduate medical education from a maximum of five yea to a maximum of four years were defeated.

19. **Smokeless tobacco**—Legislation to require health warning labels on and to bar broadcast media advertising for smokeless tobacco products was enacted.

20. **Alcoholic beverage warnings**—Legislation to require warning labels on alcoholic beverages has been reported to the Senate floor.

21. **Interest on Medicare claims**—Legislation to requir interest on Medicare claims that are not paid within 30 days has been enacted.

22. **Clinical lab competitic bid**—A moratorium on clinica laboratory competitive biddi demonstration projects has been extended for one year.

23. **Tax status/abortion**—Proposals were defeated that would have stripped tax exempt status from entities tha were involved with or performed abortion services.

24. **Relative value study (RVS) completion date**—Legislation was enacted to d lay the date by which HHS must complete an RVS to allo completion of the Harvard/AMA RVS (July 1, 1988).

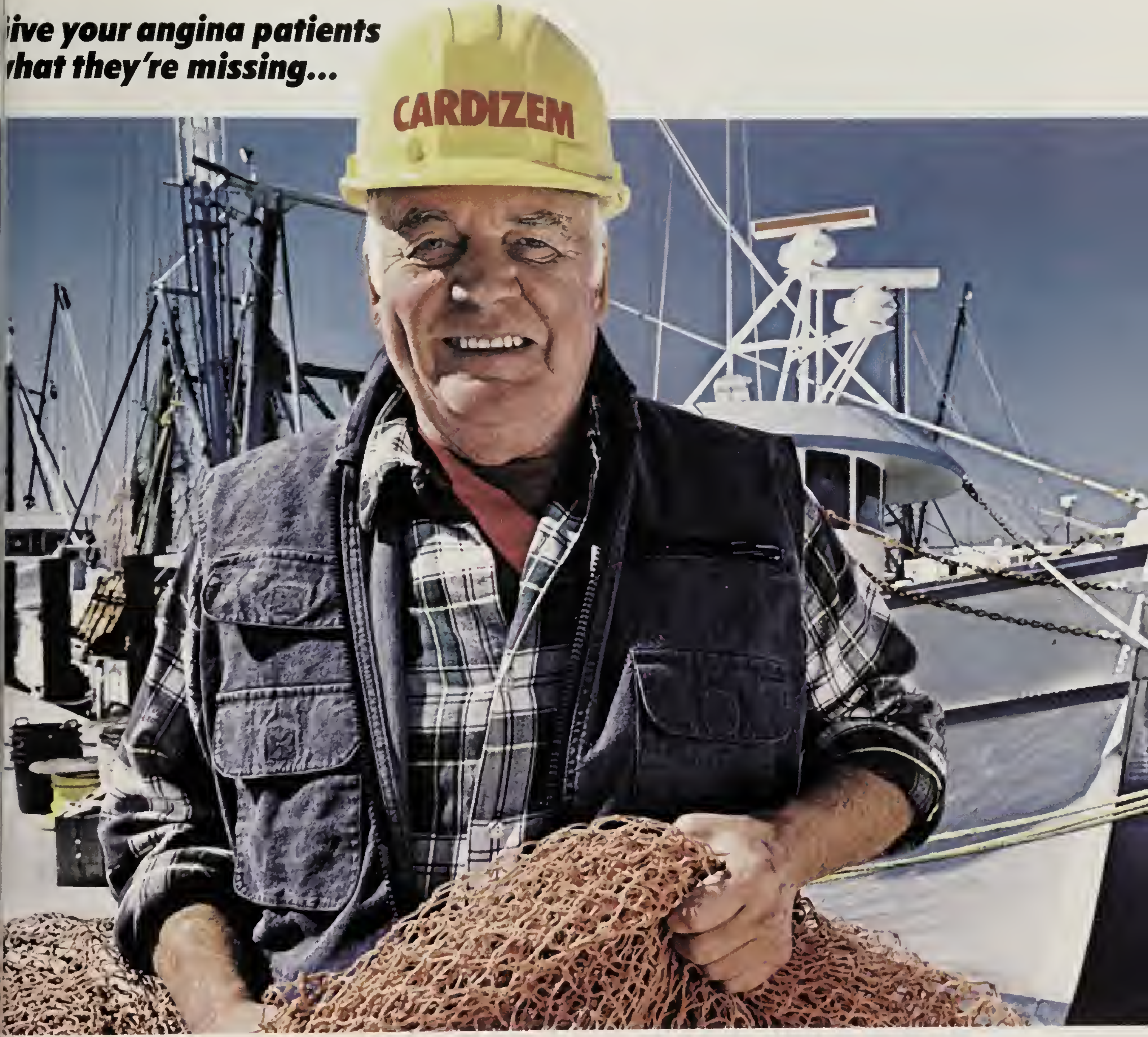
25. **MEI recalibrations**—Retroactive recalibration of t MEI was not allowed.

26. **Preservation of 401(K plans**—In the tax act 401(K) plans were preserved.

27. **Airline emergency kits**—Federal regulations wer changed to require an expanded emergency kit on cor mercial airlines. A two year study also was mandated to r quire data collection on med cal emergencies.

28. **Boxing**—The House passed legislation that would establish a US Boxing Commi sion to establish safety standards for boxing matches.☐

ive your angina patients
hat they're missing...



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***See Warnings and Precautions.**

Please see brief summary of prescribing information on the next page.

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Brief Summary
Professional Use Information
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(diltiazem HCl) 30 mg and 60 mg Tablets

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.
Nervous System.	Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.
Gastrointestinal:	Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.
Dermatologic:	Petechiae, pruritus, photosensitivity, urticaria.
Other:	Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. Issued 11/85

See complete Professional Use Information before prescribing.

References: 1. Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers: Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983, 106(6):1341-1347. **2.** Shapiro W: Calcium channel blockers. Actions on the heart and uses in ischemic heart disease. Consultant 1984,24(Dec):150-159. **3.** Johnston DL, Lesoway R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985,55:680-687. **4.** Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39. **5.** Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982;50(Sept):94-116.

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By Philip Margolis, MD

n memoriam

Dean P. Carron, MD
1921-1986

As you know, Dean Carron, MD, died several weeks o. Dean's death has stimu- ed a host of feelings inside e, some of which I would like express in the publication of Society that meant a great al to Dean, and one for ich he worked unstintingly. President-elect of Wastenaw unty Medical Society, and ore importantly, as a good end of the entire family, I sh to share with you a few emories and thoughts.

Dean was actually one of the st persons I met in Michigan. lways knew where I stood th Dean, and what he was inking and feeling. We im- ediately liked one another, d indeed, upon my arrival— r two weeks without my mily—,the Carrons insisted at I stay with them. It was a arm and hospitable invitation hich I will never forget. Ironically, Dean suffered a severe myocardial infarction during this stay with the Carrons so I came to know and love them in a time of crisis and travail. That's the way Dean and his family, his wife Mildred and four fine children, have always been: helpful and supportive, straight-forward and down-to-earth.

Doctor Carron

Dean Carron was on the Community Mental Health Board when I became its first director in 1966. He quickly incorporated and espoused the community mental health philosophy of providing more services to more people. Thus, we have not only lost a leader, but we have also lost a man who was interested in helping people to feel better. And they did, in part because Dean wanted them to—the mark of a true physician.

Dean practiced medicine with tremendous dedication and energy. Some of his former patients and colleagues have, unbidden, attested to the strength, quantity and quality of his professional and his personal services.

He served as a delegate from 1962-73 and as an alternate from 1974-75 to the MSMS House of Delegates. Dean also was Washtenaw County Medical Society president in 1972.

Dean was a giver of service. He accomplished an astounding amount in a short period of time. He died too young. Perhaps I sensed he would, even twenty years ago, but his deeds and attainments, and Dean himself, will live on . . . ☐

---

ctor Margolis, Ann Arbor psy- iatrist, originally wrote this arti- e for the October issue, ashtenaw County Medical Soci- y *Bulletin*. It is reprinted with rmission.

MSMS, MSMS/A, AMA & MEDICAL ASSISTANTS

January 21, 1987 — MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, contact: William Madigan (517)337-1351.

February 20-22, 1987 — AMA National Leadership Conference, Chicago, contact: Michelle Zaba (312)645-4430.

February 25-27, 1987 — AMA — Medical Profession: Enduring Values and New Challenges, Los Angeles, contact: Pat Clark (312)645-4497.

March 18, 1987 — MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, contact: William Madigan (517)337-1351.

March 21, 1987 — MSMS Hospital Medical Staff Section Annual Meeting, Hyatt Regency, Dearborn, contact: Thomas White, MSMS Headquarters, (517)337-1351.

April 24-25, 1987 — MSMS House of Delegates, Amway Grand Plaza, Grand Rapids, contact: William Madigan (517)337-1351.

May 7-8, 1987 — AMA National Conference on AIDS, Marriott Hotel, Chicago, contact: Pat Clark, AMA (312)645-4497.

July 16-19, 1987 — MSMS Board of Directors Midsummer Meeting, Deer Lake, Boyne Mountain, contact: William Madigan (517)337-1351.

September 23, 1987 — MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, contact: William Madigan (517)337-1351.

November 18, 1987 — MSMS Board of Directors Meeting, MSMS Headquarters, contact: William Madigan (517) 337-1351.

OTHER MEETINGS

January 9, 1987 — Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Publi Health, Room 3A, Lansing, contact: David J. Lieberman, MD, President, Michigan Heal Officers Association, 650 Stewart Road, Monroe 48161 (313)243-7144.

January 14, 1987 — Michigan Allergy Society, Program: Animal Dander Allergy, Dearborn Inn, contact: Viola Heins MSMS Headquarters (517) 337-1351.

January 29-30, 1987 — Mich gan Section, ACOG, MSACOC Annual Snow Meeting, Gaylord, contact: James W. Gell, MD, program chairman, (313) 335-9207.

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ruary 4-5, 1987 — Michi- Health Officers Associa- , Directors Conference, way Grand Plaza Hotel, nd Rapids, contact: David J. erman, MD, President, higan Health Officers Association, 650 Stewart Road, nroe 48161, (313)243- 4.

rch 5, 1987 — Michigan alth Officers Association, rd of Directors Meeting, higan Department of Public alth, Room 1D, Lansing, tact: David J. Lieberman, , President, Michigan Health icers Association, 650 wart Road, Monroe 48161, 3)243-7144.

ril 3, 1987 — Michigan alth Officers Association, rd of Directors Meeting, higan Department of Public alth, Room 1D, contact: vid J. Lieberman, MD, Presi- t, Michigan Health Officers sociation, 650 Stewart Road, Monroe 48161, (313) 243-7144.

May 1, 1987 — Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, President, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161, (313) 243-7144.

June 5, 1987 — Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, President, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161, (313) 243-7144.

July 10, 1987 — Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, President, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161, (313) 243-7144.

August 18-21, 1987 — Michigan Health Officers Association, Annual General Membership Meeting, Grand Traverse Resort, Traverse City, contact: David J. Lieberman, MD, President, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161, (313) 243-7144.

September 4, 1987 — Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, President, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161, (313)243-7144.

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Correction:

Inaccurate information regarding State Bar of Michigan dues was published in the October, 1986 issue. State Bar of Michigan dues for active members licensed for more than three years actually are $150 and have been at that level for the past 10 years.☐

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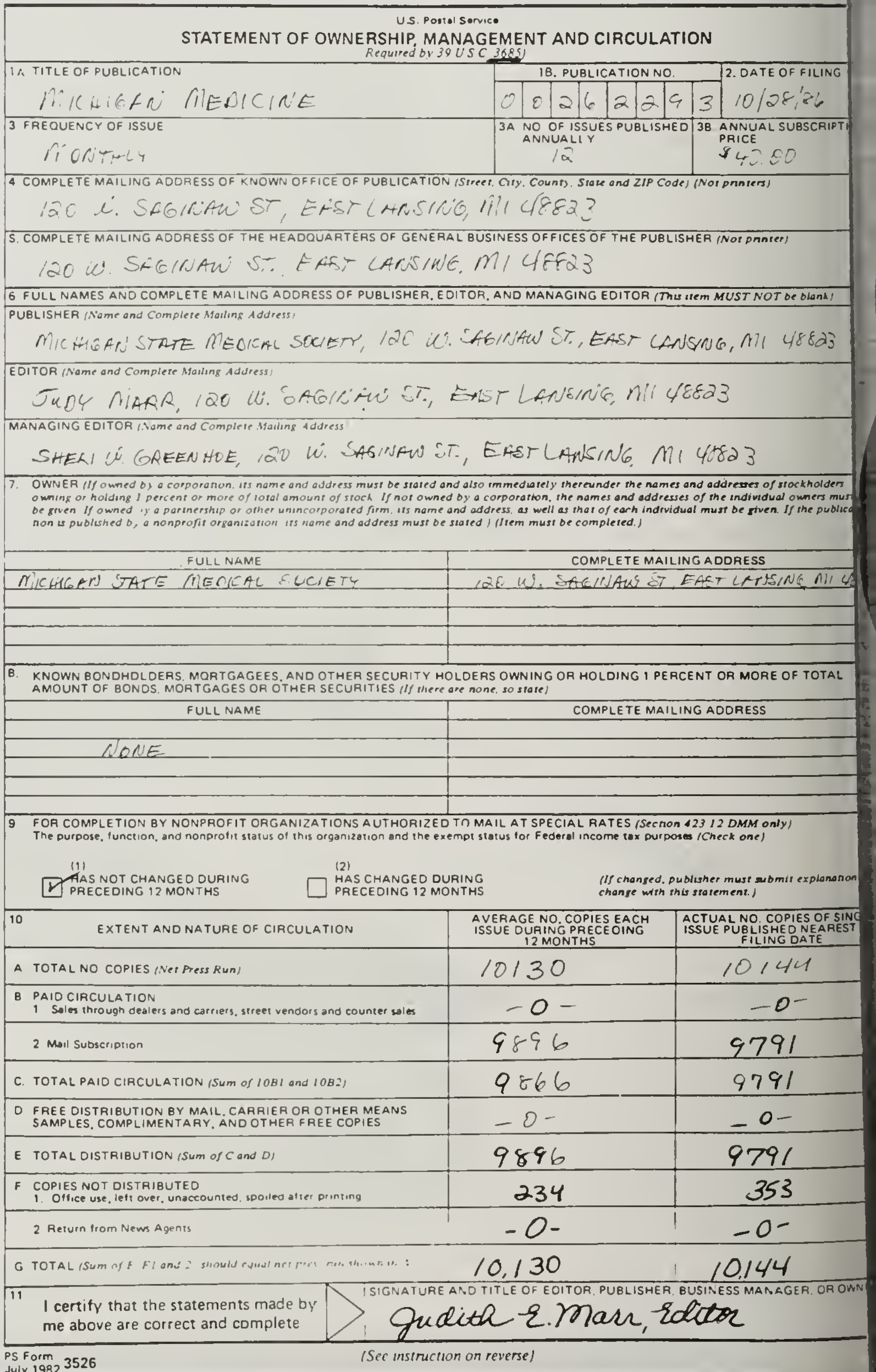

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This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 5D% of the bioavailability of the single entity Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for Institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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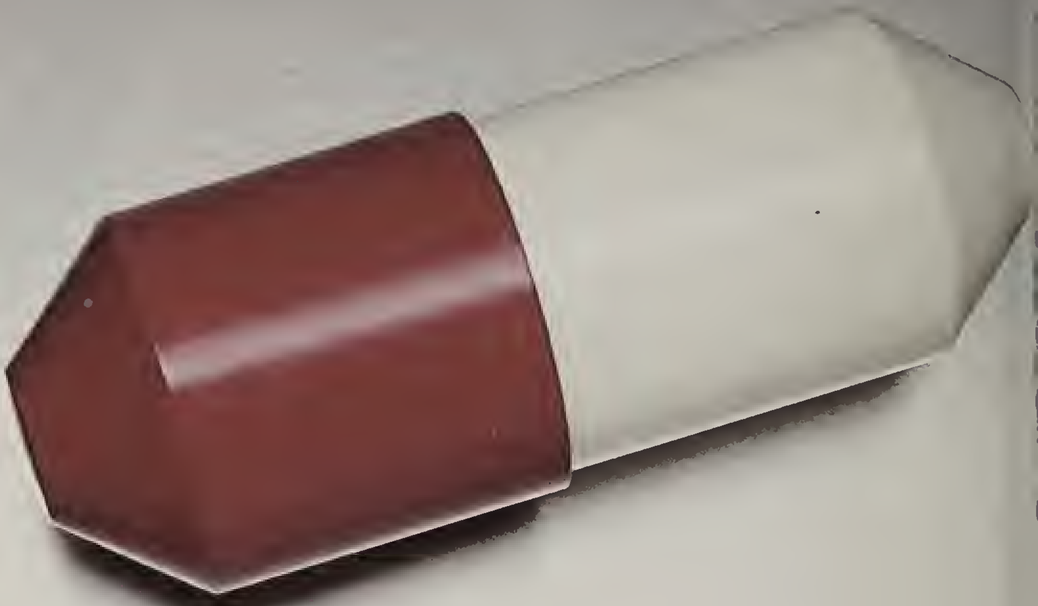

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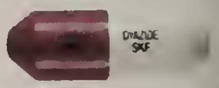

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Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

Date: December 15-19, Principles of Manual Medicine. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine, College of Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: January 17, 1987 '87 Superbowl of Osteopathic Medicine. Location: Michigan Osteopathic Medical Center, Detroit. **Sponsor:** Michigan Osteopathic Medical Center. **Contact:** Sheila Smith, Coordinator, CME & Special Programs, Michigan Osteopathic Medical Center, 2700 Martin Luther King Jr., Blvd., Detroit 48208 (313)361-8020. **Approved for:** 7 hours of Category Credit.

Date: February 1-6, 1987 Eleventh Annual Midwinter Family Practice Conference. Location: Boyne Highlands Inn, Harbor Springs. **Sponsor:** University of Michigan Medical School. **Contact:** Gayle Fox, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor 49109-0201 (313)763-1400. **Approved for:** 21.5 hours of Category I Credit.

Date: February 11, 1987 Update in Diabetes Management. Location: Fairlane Manor, Dearborn. **Sponsor:** Wayne State University of Medicine. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, 4201 St. Antoine, 4H, Detroit 48201 (313)577-1180. **Approved for:** 7 hours of Category I Credit.

Date: March 4, 1987 Stroke: A Multidisciplinary Approach. Location: Kalamazoo Hilton Inn. **Sponsor:** Borgess Medical Center neurophysiology Department and Southwestern Michigan Area Health Education Center. **Contact:** Bill Daam, Neurophysiology Department, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001 (616)383-4895. **Approved**
5.75 hours of Category I Credit.

Date: March 12-17, 1987 Ophthalm
ogy: Basic and Clinical Review Cou
Location: Hotel Pontchartrain, Detr
Sponsor: Kresge Eye Institute of Wa
State University School of Medicine. **C**
tact: Division of Continuing Medical E
cation, Wayne State University Schoo
Medicine, 4H University Health Cen
4201 St. Antoine, Detroit 48201 (3
577-1180. **Approved for:** 42 hours
Category 1 Credit.

Date: March 13-14, 1987 Annual P
graduate Course in Obstetrics and Gy
cology: Challenges and Changes of
1980s. Location: Towsley Center, Uni
sity of Michigan. **Sponsor:** University
Michigan Medical School. **Contact:** Ga
Fox, Office of Continuing Medical Edu
tion, The University of Michigan, Tows
Center, Box 0201, Ann Arbor 481
0201 (313)763-1400. **Approved**
12.3 hours of Category I Credit.

Date: March 18, 1987 Dermatology.
cation: Saint John Hospital, Detroit. **Sp**
sor: Saint John Hospital Continuing M
ical Education Committee. **Contact:** C
Mastroianni, Program Coordinator, C
Saint John Hospital, 22101 Moross Rd
Detroit 48236 (313)343-3877. **Appro**
for: 8 hours of Category I Credit.

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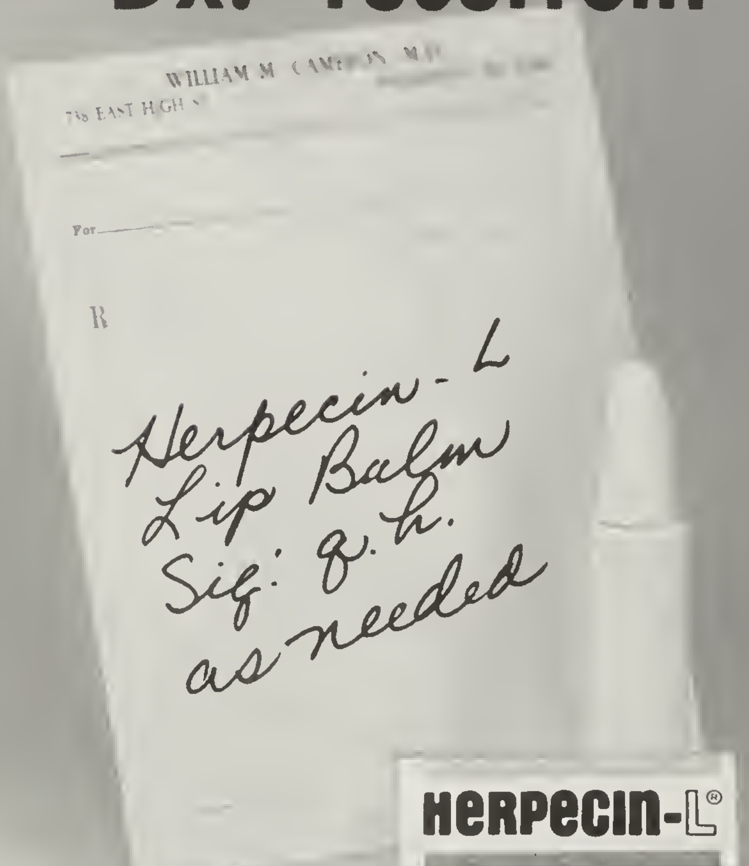

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**: March 24-28, 1987 Family Prac-
-Eleventh Annual Spring Refresher
oard Examination Review. Location:**
ley Center, University of Michigan.
sor: University of Michigan Medical
ol. **Contact:** Georgia Barton, Office
ntinuing Medical Education, Univer-
f Michigan Medical School, Towsley
er, Box 0201, Ann Arbor 48109-
(313)763-1400. **Approved for:**
5 hours of Category I Credit.

**: March 25-26, 1987 Michigan Con-
ce on Maternal and Perinatal Health.
tion:** Hyatt Regency, Dearborn. **Spon-**
MSMS. **Contact:** Sherry Fent, 120 W.
aw, East Lansing 48823 (517)337-
. **Approved for:** 13 hours of Cate-
I Credit.

**: April 3-5, 1987 Tutorial on Level I
ascial Release Technique. Location:**
gg Center for Continuing Education,
Sponsor: MSU College of Osteo-
c Medicine and College of Human
cine. **Contact:** Sandy Kilbourn, MA,
tor of Continuing Medical Education,
College of Osteopathic Medicine,
5 E. Fee Hall, East Lansing 48824
)353-9714. **Approved for:** 24 hours
tegory I Credit.

**: May 15-17, 1987 The Differential
nosis of Musculoskeletal Pain: Em-
is on the Low Back. Location:** Kel-
Center for Continuing Education,
Sponsor: MSU College of Os-
athic Medicine. **Contact:** Sandy Kil-
n, Director of Continuing Medical
ation, MSU College of Osteopathic
cine, A306 E. Fee Hall, East Lansing,
3824 (517)353-9714. **Approved for:**
ours of Category I Credit.

**: May 20, 1987 Current Update in
reatment of Breast Carcinoma. Lo-
n:** Saint John Hospital, Detroit. **Spon-**
Saint John Hospital Continuing Med-
ducation Committee. **Contact:** Carol
roianni, Program Coordinator, CME,
John Hospital, 22101 Moross Road,
it 48236 (313)343-3877. **Approved**
3 hours of Category I Credit.

**: May 27-31, 1987 Tutorial on Level
nual Medicine Techniques (Below Di-
agm). Location:** Kellogg Center for
inuing Education, MSU. **Sponsor:**
College of Osteopathic Medicine and
ge of Human Medicine. **Contact:**
y Kilbourn, Director of Continuing
cal Education, MSU College of Oste-
ic Medicine, A306 E. Fee Hall, East
ng 48824 (517)353-9714. **Ap-
ed for:** 40 hours of Category I Credit.

**: June 4-5, 1987 13th Annual Kala-
o Symposium for Michigan Neona-
ists and Neonatal Fellows. Location:**
ore Center for Health Education,
son Methodist Hospital, Kalamazoo.
sor: Neonatology Services of the
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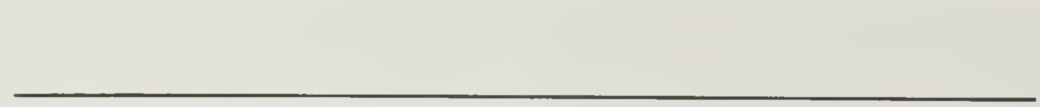

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Medical politics—don't stop the treatment

Politics is a continuous process. As physicians we are trained to take a careful history, do a complete physical, make the proper diagnosis and prescribe the appropriate therapy. Politics is not like treating an acute illness or injury but rather like caring for a chronic skin disease—if you stop the treatment, the condition gets worse.

This past fall the legislature passed and Governor Blanchard signed into law a package of tort reform bills. It was not all that we wanted, but a good step forward. In October of 1985, we had a highly successful march on Lansing with over 11,000 doctors and other members of the medical family participating. We were promised legislation by Christmas. As you know, the wheels got mired in mud and it was eight months later before the package was passed. Insurance Commissioner Herman Coleman told us at our midsummer Board of Directors meeting how impressed he and everyone else in Lansing was with the march but how quickly over the next four to five weeks the effect diminished.

The past year has been one of the best in MDPAC's history. Chairman Tom Stone and MSMS staffer Dan Farhat deserve accolades for a job well done. Our membership stands at an impressive 3,500 members with 585 sustaining members—a new record. Put in a more proper perspective, however, only 35 percent of our MSMS members were willing to commit $50 to political action and only two percent contributed $150. Thus only 585 of us were willing to give 41 cents a day to help keep our profession free.

MDPAC was also very successful in the 1986 elections. John Schwartz, MD, was elected to the Michigan Senate and Nancy Crandall, wife of MSMS Past President Don Crandall, MD, lost her bid to the Michigan House of Representatives. MDPAC backed these two with the maximum contribution allowed by law. We had many successes in other races for the Senate and the House but we lost some close races. Possibly some of those in which we were unsuccessful could have been turned around if we had been able to help a little more. But, we simply ran out of money.

AMPAC also was very successful in working for you. I have been privileged for the past two years to have served as chairman of the AMPAC Board. This year we embarked on an ambitious, innovative, independent expenditure in two Congressional districts—the California ninth and the I diana tenth. Although we di not win either of these races we did send a message that AMPAC may choose to beco involved in selected political races, and if it so chooses, that can be an unprecedente significant recourse.

The elections are over for 1986 and the legislative process begins. Again we wil be faced with myriad bills which will affect your profession. MSMS will have introduced bills to further refo the tort system: we need a meaningful cap on awards fo pain and suffering; a reasonable statute of limitations an some way to stop the endles frivolous suits. We need to stay involved so the laws passed are ones we can live with and not further proof th the third greatest lie ever tol "I'm from the government ar I'm here to help you," lives on.

As you pay your 1987 MS and AMA dues, don't regard the MDPAC portion as something you can get away without paying. Rather take out your personal checkbook and write a check for $150 f your MDPAC/AMPAC sustaini membership. Forty-one cents day is a small price to pay f professional freedom. Your government is highly involve in the political process. Remember, if you stop the treatment, the condition gets worse!!!☐

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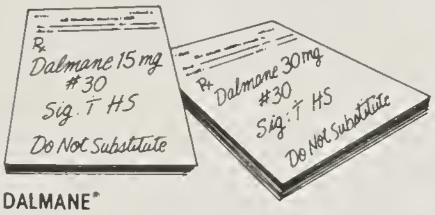

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